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ABSTRACT

The nine papers in this collection are directed toward aspects of family treatment in social work practice. Ranging in focus across the life span from infants to older adults and including material about minority group families in America, all of the papers discuss current practices and programs. The first paper discusses primary prevention practice with families of infants. The second considers the experience of one residential treatment center in changing from a traditional child-centered treatment approach to one more family-centered in nature. Intrafamilial child sexual abuse and the manner in which the underlying treatment assumptions of one program affected the development of that program's structure are discussed in the third paper, while the fourth offers ideas about social work practice with Asian American families. Guidelines for helping troubled teenagers in blended and single-parent families are provided in the fifth paper; the sixth describes two models for treating families who abuse children (the generic family model and the family management model). The seventh paper in the collection discusses an intervention approach utilizing social networks to assist Mexican American families, while the eighth paper discusses aspects of the work of the conciliation court of Los Angeles County. In conclusion, the ninth and final paper describes a mutual help program for widows and widowers. (RH)

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# Social Work Papers

The School of Social Work

University of Southern California

University Centennial Edition
Family Treatment in Social Work

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# EDITORIAL NOTES

The Editorial Board, charged with planning and producing this University Centennial Edition made an initial decision to have an all-alumni issue devoted to the family. Most authors are making their initial appearance in print. They write directly from practice, thus meeting a criticism of some current literature: that it represents only a peripheral concern for how those on the front line are helping seriously troubled people to cope with their problems.

As Social Work has returned full circle to a family focus, the American family is beleaguered by failure of traditional supports and systematically victimized by anti-family government policies. The family is, in fact, hostage to powerful forces intent on legislating morality while denying funds for maintenance, and to groups who insist nostalgically on conventional family forms, often equated with the tenets of specific religious sects.

These papers reflect a profession engaged in efforts to deal with today's realities: prevention of the troubled marital relationships that are sometimes brought on by the birth of the first child, and addressing the problems of large cultural minorities, some of whom live in isolated areas as well as in an alien culture. The power of joining forces with legal and judicial systems is reflected in papers which address serious problems of child abuse and divided custody. Several authors clarify and advance the role of the professional in collaboration with self-help groups and natural networks, thus anchoring and extending available services. Some of the practice described includes planned organizational change to engage families in residential treatment and the mobilization of helping resources in an entire community to recognize and treat families where children are sexually abused. The papers are grouped in approximate life cycle order. Several focus on families with troubled adolescents.

Beyond the papers included in this edition were excellent proposals that were not developed into full-length papers. The topics of these proposals ranged from preventive work with families of infants (those born ill or damaged and those whose teen-age parents are attempting to combine family responsibilities with high school studies), to work with families of psychiatric patients, and alternative and emerging family forms, including homosexual families.

This issue owes much to Ruth Britton, who devoted many hours and great skill to editorial tasks as well as offering consultation to authors, and to Marquis Wallace, who identified several recent graduates as potential authors and encouraged their efforts.

--Elizabeth McBroom, Editor

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# A PRIMARY PREVENTION PRACTICE: WORKING WITH FAMILIES OF INFANTS

*by*

*Judy Rothman*

## Abstract

Parenthood is filled with important tasks for which there is little preparation. For many couples, support systems such as the extended family do not exist. Couples prepare for the physical aspects of childbearing but not for the transition to a system which will nurture an infant. The birth of the first baby is a major crisis in the life cycle of the family which each unit must resolve in order to restore its equilibrium. The marital dyad, now a triad, must restructure itself. Inclusion of the father in a sometimes exclusive mother/infant duality can be particularly difficult.

Social work practice, both in agency and independent settings, is beginning to address the needs of the developing family. Services are offered to enable couples to bridge the gap from nurturing each other to parenting an infant as well.

The Department of Family and Child Psychiatry, Thalians Community Mental Health Center, Cedars-Sinai Medical Center, offers a variety of services to families with infants, including telephone and in-person consultations, home visits and mother/infant groups. The curricula in social work, psychology and psychiatry also include an early intervention experience as mental health professionals recognize the value of primary prevention of chronically maladaptive patterns in family relationships.

• • •

> Parenthood, contrary to popular belief, doesn't come naturally. In fact, parenthood is remarkable in that it is one of life's few occupations in which complicated and vitally important tasks are assigned randomly to men and women with little preparation or training supply.
>
> —Bertram S. Brown, Director
> National Institute of Mental Health

Some expectant parents carefully prepare themselves for the physical aspects of childbearing, but these same well-educated people are often befuddled when actual parenthood is thrust upon them. To complicate the situation, the extended family as a support system for young couples is often no longer available. Enabling couples to make the transition into parenthood with minimal stress is at the core of social work with families of infants in a primary prevention practice. The importance of early prevention is underscored by the inclusion of this approach in clinical practice as well as in the education of mental health professionals. A prime example of preventive services for families of normal infants is the early prevention program offered by the Department of Family and Child Psychiatry, Thalians Community Mental Health Center, Cedars-Sinai Medical Center. This program consists of consultations, in person and by telephone, with parents of infants as well as group work with mothers and their babies. In addition, the concept of early prevention has been utilized as a vehicle for training students in the Department of Psychiatry and Biobehavioral Sciences of the School of Medicine, University of California, Los Angeles. Primary prevention is also becoming an appropriate service for social workers in private practice where families of infants constitute a significant part of the clientele.

A review of the origin and development of primary prevention with families of infants will aid in the understanding of its current status. In 1970, a consultation and guidance service for parents of very young children was initiated.[1] An earlier study had demonstrated the value of brief, early consultation and guidance.[2] As a result of this study, the Center hoped to make consultation service available to families referred by pediatricians and nursery school teachers. The early prevention program was on a small scale because staff resources were limited. Thus began the Preschool and Infant Parenting Service (PIPS). Soon the program required the services of a larger professional staff, and a corps of volunteer social workers was recruited.[3] After four years, part-time paid positions were made available in the Department to three experienced volunteer clinicians in order to increase the stability of PIPS, which is one of the community outreach programs in the Thalians Community Mental Health Center supported by the National Institute of Mental Health.

Although in the beginning PIPS was intended to be a service provided directly at the Thalians Community Mental Health Center, parents calling in response to newspaper and radio publicity showed that large numbers wanted to talk about child-rearing problems but many could not travel easily to the Center.[4] As a result, an important innovation was introduced: a free telephone consultation service to parents of children under five, the Warm Line, which became the port of entry for PIPS. While its continuing purpose was to provide education and guidance to parents of normal infants, toddlers and preschoolers, it also became a service of case finding for young children and families at high risk for developmental dysfunctions. Parents were invited to call for help with everyday worries and questions related to their child's development.[5] The calls relating to new infants, particularly those with colic or other special needs, were usually directed to staff with expertise in early development.

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[1] Helen Reid, a clinical social worker in the Department of Family & Child Psychiatry, Thalians Community Mental Health Center, Cedars-Sinai Medical Center, drawing upon her long experience in the Department's therapeutic nursery school, began this consultation service for parents of young children, birth to five.

[2] This study was done by Helen Reid, M.S.W., in conjunction with Bernice Augenbraun, M.S.W., and David Freedman, M.D., a pediatrician.

[3] The author's association with PIPS began in 1971 as one of these professional volunteers. In 1975, the author became part of the salaried staff of PIPS.

[4] Helen Reid & Saul Brown, M.D., "The Preschool and Infant Parenting Service '*PIPS*': Fresh Approaches in the Philosophy and Practice of Child Rearing," in *Public Health Currents, 20 (1980)*.

[5] *Ibid.*

Shortly after establishing the Warm Line, the PIPS program began experimenting with brief service groups for parents who were interested in discussing common issues of child rearing. Originally the groups were composed of mothers. Later, couples' groups were offered in the evening. Soon the service was expanded to include the children in a mother/toddler group program. Later, a similar program for mothers and infants was developed. A drop-in format was originally tried for both mother/infant and mother/toddler groups. However this was replaced by six-session series in order to promote group continuity with clear beginnings and endings. A parent/infant group on Saturday mornings was added to enable fathers, who were becoming more involved in early infancy with the advent of birth preparation classes, to participate.

Currently, mother/infant groups are ongoing with fees on a sliding scale. New mothers are added to the sessions as space allows, with eight mother/infant dyads included at a given time. Some mothers attend only the first eight sessions while others continue until their infants "graduate." This format allows for consistent group continuity while enabling new mothers whose needs are great in the first few critical months of the infant's life to be added regularly. In response to the large number of requests for infant groups, and because the issues are different in the first six months as opposed to the second six months of life, two mother/infant programs based on the child's age were established.

As an early prevention program with appeal to parents of normal children, PIPS was able to secure a unique community setting called the Parents House. Because there are complications for many parents in coming to a large medical center, the staff established a satellite setting, small house with a backyard to provide an environment. Staff leaders guide the discussions which occur in a low-keyed, problem-solving and supportive manner. As the mother/infant dyads interact, their actual interaction becomes material for group discussion.

Occasionally a family is in need of a brief but more focused and intensive therapeutic experience than a group can provide, so a program of therapeutic intervention in a brief service mode was developed.[6] It is entitled Mother/Infant Unit (MIU), and is part of the clinical in contrast to the educational track of the PIPS program. In the MIU service, an initial consultation is followed by a series of five or six family sessions either in the Mental Health Center or in the family's home. The problems of colic or severe irritability in infants lend themselves extremely well to this modality as the parents become the agents of change and thus gain confidence in their caretaking behavior.

The PIPS model of services, both the Warm Line and mother/infant groups, has been copied in many locales. For example, in 1978, the UCLA Department of Child Psychiatry, Neuropsychiatric Institute, began a primary prevention program similar to the PIPS mother-infant service. Entitled the Well Child Clinic, it offered mother/infant and mother/toddler groups.[7] In addition to offering a service to the community, the group modality has been used as a medium for training residents and fellows in Child Psychiatry and Ph.D. candidates in Clinical Psychology in a mother/infant approach to primary prevention.[8]

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[6] Shelley Gallenson, a child development specialist in the Cheerful Helpers Preschool program of the Thalians Community Mental Health Center, developed this brief service approach.

The format involves a student participating with an experienced clinician as co-leader of two time-limited groups (eight sessions) composed of mothers and infants. In addition, one evening meeting with the fathers present provides the student with a unique look at the total family in action. Two separate group experiences are provided. The students use the first group to observe the mother/infant interaction while watching the interventions. Their direct, active participation is expected in the second group experience. Finally, experiences in interviewing families with infants is offered to the student in the screening and follow-up sessions at the beginning and end of each group series.

Primary prevention also has a role in private practice as families of infants often seek help from independent clinicians. Many couples are unable to restore the kind of equilibrium they had achieved prior to the birth of the baby. In those cases, conjoint or individual psychotherapy on a long term basis may be appropriate.

## *Family Life Cycle*

Although, of necessity, the unit most often worked with in primary prevention is the mother/infant dyad, the focus still remains on the family. Even in mother/infant group discussions, the role of the father is an important issue. The orientation in PIPS is clearly with the family unit as a whole. Its parent Department early became a center for the practice and teaching of family therapy.[9]

Dr. Saul Brown has written that "a progressive and yet recurring cycle of change occurs in each family."[10] Families are also biosocial systems in which "a family group functions like a general system with many interlocking and interacting subcomponents or subsystems."[11] The husband/wife dyad, mother/child dyad, and father/child dyad are all family subsystems. The theory of the family life cycle uses, as a frame of reference, Erikson's concepts of stages and crises in human development. Brown has extended this concept into a view of the developmental progression of a family group.

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[7] Miriam Meyer, a social worker on the staff of the UCLA Department of Child Psychiatry, Neuropsychiatric Institute, initiated the Well Child Clinic which was modeled on the PIPS group program.

[8] The author was appointed three years ago to serve on the clinical faculty of the Department of Psychiatry and Biobehavioral Sciences of the UCLA School of Medicine. Dr. Christopher Heinicke of that department currently supervises the mother/infant program.

[9] The Department for many years has been headed by Saul Brown, M.D., now chief of the Department of Psychiatry, Thalians Community Mental Health Center. Dr. Brown's philosophy has strongly influenced the direction that the PIPS programs have taken.

[10] Saul Brown, "Family Experience and Change," in *Family Roots of Social Learning and Behavior Disorders* edited by R. Friedman, (Springfield: Charles C. Thomas, 1973) 1.

[11] *Ibid.*

> Just as the ego functions of an individual evolve through a series of developmental tasks and crises, so do the interactional patterns of an entire family group, and just as failures in individual development contaminate later phases in definite ways, so do familial failures to master the major phases of the family cycle affect the psychological functioning of the family members in each successive period of development.[12]

The first phase of family development entails primary commitment between marital partners. The couple needs to consider that the marriage is now the primary level of investment which takes precedence over other emotional involvements. If primary commitment was established, this included mutual nurturing of each spouse by the other, for the couple must become "open and responsive to dependency needs in each other."[13] The couple literally parents each other in a relatively unencumbered way. Later, they can transfer their nurturing attitude to the caretaking of their children. If, however, a sense of primary commitment is tentative then "the newly formed marital dyad will not be able to provide consistently integrative parenthood in the next phase."[14]

The birth of the first baby interrupts this flow of mutual nurture between husband and wife. All of the nurturing energy is now directed toward the infant who sits at the apex of the family triangle. Little mutual nurture is left for the parents, particularly in the first three months when they find their infant's behavior is baffling. Feelings of severe self doubt and inadequacy, stirred up in caring for the infant and complicated by expectations of competence, may be overwhelming to some new parents particularly if the infant has special needs, such as colic. "A downward spiral of dispiriting defeat and of mutual projection of failure can easily become established."[15]

Thus the infant's birth may be a serious disruption in the developing family and cause upheavals which create disequilibrium in both parents. It is also clear that this critical event produces an unparalleled impact on the couple who experience it as a major family crisis. To resolve this crisis, the dyad must become a triad in a restructuring process which moves the family from the phase of primary commitment to the creation of a nurturing system.[16] The transition requires changes in the marital contract. Many couples had made tacit or even written agreements prior to the infant's birth but these contracts are no longer valid. They must deal with new issues and complexities, particularly the lack of spontaneity in daily life they once enjoyed. A simple event like an evening out becomes a major production.

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[12] *Ibid.*, 8.

[13] *Ibid.*, 10.

[14] Saul Brown, "Functions Tasks, and Stresses of Parenting: Implications for Guidance," in *Helping Parents Help Their Children* edited by L. Eugene Arnold. (New York: Brunner/Mazel, 1978) 24.

[15] *Ibid.*, 32.

[16] Brown, "Family Experience and Change," 9.

Renegotiation of the old contract is essential to restore equilibrium of the family.

### *Integrating The Infant – The Transition*

The transition to parenthood can be better understood if attention is paid to what occurs developmentally within the infant and how this affects his parents. This process must be observed interactionally, for at its core are the reciprocal responses in the mother/infant dyad involving attachment behavior of the infant which evokes caretaking responses from the parent.[17] Bowlby describes the phenomenon of attachment behavior as a need in infants for "an inbuilt propensity to be in touch with and cling to a human being. In this sense there is a 'need' for an object independent of food which is as primary as the 'need' for food and warmth."[18]

Mahler also pioneered an approach to infant development dependent on interactional patterns. She characterizes the first few weeks of life as the normal autistic phase; the infant is preoccupied with events inside his body and unaware of an outside caretaker. At about four weeks of age, a transformation occurs based on the infant's continuous attempts to maintain homeostasis. There begins a "dim awareness of the need satisfying object which marks the beginning of the phase of normal symbiosis in which the infant behaves and functions as though he and his mother were an omnipotent system — a dual unity within one common boundary."[19] The essential feature of symbiosis is fusion or social interdependence with mother. Kaplan simplifies Mahler's ideas into the concept of a state of "oneness," in which the baby is liberated from his preoccupation with his internal existence by an illusion that he is at one with an outer existence, namely his mother or primary caretaker.[20] Kaplan categorizes "one of the pinnacle attainments of a human life— the infant's special attachment to his mother."[21] This unique bond continues until about five months of age. The baby then is ready to move out of the symbiotic orbit of mother/infant oneness into the stage of what Mahler terms "hatching" in which "the infant has become more permanently alert and perceptive to the stimuli of his environment."[22] The transition from autism to symbiosis to the beginning of individuation, separation is thus complete.

Great emphasis has been placed on the bonding or attachment patterns on the part of the infant, but not as much attention has been paid to the energy a mother invests in this interaction. She frequently becomes locked into this system with her infant to the exclusion of all others, including her spouse. This is particularly true if she has unresolved issues of attachment and separation within her own psyche, or if the infant has some special needs such as colic or physical difficulties at birth. The mother's guilt that she is somehow to blame and needs to repair the "damage" herself can lead to an even greater exclusiveness with the infant and further alienation from her spouse.

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[17] John Bowlby, *Attachment*, (New York: Basic Books, 1969) 182.

[18] *Ibid.*, 178.

[19] Margaret Mahler, *The Psychological Birth of the Human Infant* (New York: Basic Books, 1975) 44.

[20] Louise Kaplan, *Oneness and Separateness* (New York: Simon and Shuster, 1978) 89.

[21] *Ibid.*, 90.

[22] Mahler, *Psychological Birth of the Human Infant*, 290.

In reality, an infant with special needs is exhausting for the mother, and she needs her spouse to refuel her so she does not get depleted. Breastfeeding can be a further complication as mother alone becomes the source of all nourishment and comfort as the pattern of exclusiveness continues. This phenomenon is completely different from what was fantasized by the couple prior to the infant's birth. When they attended childbirth preparation classes, they envisioned a partnership in caring for the infant similar to the partnership they were practicing for labor and delivery. Disappointment and anger can result when reality does not mesh with fantasy.

What happens to the father during the first four to five months of the infant's life when bonding, special attachment, and "oneness" with the primary caretaker is occuring? Depending on his own vulnerabilities he may or not be able to be a part of this system. How he perceives the sometimes exclusive duality between mother and child, how he responds to her and the infant depends on several variables:

Does the mother/infant attachment system reawaken feelings of his being excluded in his family of origin, or is he comfortable in joining his spouse and child in creating a three-way nurturing system?

Are his feelings of resentment and rejection toward his wife and child exaggerated so that he distances himself, or can he redistribute the balance between his own dependency needs and his capacity to nurture?

If his feeling of having his needs relegated to second place is so great that he cannot empathize with the neediness of his child, or if he is so angry at having been usurped by the infant who has stolen the attention of his nurturing person, then the father will continue to be an angry outsider. Mothers can alienate or include father in the caretaking process, depending on their own psychological makeup. Even a nursing mother can encourage the father to participate in such activities as burping, changing or rocking the baby.

Disruption in familial interaction occurs not only between mother and child and father and child, but also between mother and father. "Parents are also marriage partners with responsibilities and needs in their marital relationships."[23] Frequently all nurturing from both parents goes to the infant, whether or not that infant is high risk. Each parent then finds his own dependency needs have been thwarted not only by the infant but by the other spouse as well. Their relationship has been robbed of the mutual nurturing and spontaneity they once shared, as their "coupleness" is lost to overdetermined parenting.

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[23] Bertram S. Brown *"Parents are People Too,"* (Washington, D.C.: National Institute of Mental Health, DHEW Publication NO. (ADM) 74-48, 1974), Foreword.

### *Early Family Development Project*

In recognition of the need in so many young families for early help in paving the way for a smooth transition from the husband/wife dyad to the mother/father/infant triad, a unique program, The Early Family Development Project, was devised bringing together a childbirth preparation teacher and members of the PIPS staff.[24] To be helpful to the developing family, it was obviously necessary to make contact with families of new infants earlier than the third or fourth month of life when many parents had called on their own for PIPS services. Mothers in the mother/infant groups had for many years lamented the fact that they had struggled so needlessly alone during those early bewildering weeks of the infant's life. Parents of infants with colic or severe irritability, in particular, were in great stress when they finally connected with PIPS. Even though they may have known about the services through various means of publicity such as the Warm Line card in the Cedars-Sinai maternity packet, few families made the connection to the program until the early months of uncertainty had passed. It was speculated that parents can be so enmeshed in the "baby crisis" that many of them could not get their heads above water long enough to reach out for the PIPS services, such as the Warm Line, that are readily available. Since competency is so much a part of our expectations even of inexperienced parents, many may have been reluctant to share their concerns even with professional counselors.

To remedy this situation, application was made to the Robert E. Simon Foundation which awarded a grant to PIPS enabling staff not only to reach out to families very early in the first experience, but also to provide a research component to the program to study the effects of the project on an experimental and control group with 24 families in each group. Connection to a childbirth preparation teacher gave the opportunity to meet a group of expectant parents and to offer them the services of the Early Family Development Project and later on of PIPS. A small staff of social workers and child development specialists received special training by obstetricians, pediatricians and nurse practitioners in early infant development, physical aspects of birth and recovery and problems of nursing. A gastroenterologist reviewed the origin and treatment of colic. Coupled with the skills in family diagnosis and interviewing gained in years of PIPS training, two home visits for each family were arranged.

The first visit was made by the childbirth preparation teacher whose task was to give each couple an opportunity to relive the birth experience and to give the mothers a chance to initiate nursing if they desired. A second visit by a member of the PIPS staff in the second or third week of life enabled the child development specialists to deal with non-medical concerns and to inform each family of PIPS services. Although the primary purpose of the PIPS visit was to acquaint each family with PIPS services and staff, it also provided an opportunity to observe how the family was handling the disruption of the infant's birth. Assessment of the transition the couple was making into parenthood enabled staff to begin to identify those families who were high risk and those who were able to bridge the gap between primary commitment and the creation of the nurturing system.

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[24] Helen Reid, M.S.W., Femmy de Lyser, a childbirth preparation teacher, and the author devised the program.

One factor hypothesized to be critical concerned support systems available to each family and the social isolation of the mother in particular. "Despite the fact that most parents sincerely want to provide a rich and full family life, few possess adequate skills to do so alone. The strains and isolation of today's impersonal society place heavy burdens on even the most adept and enthusiastic parents."[25] It was speculated that the program and the other PIPS services could offer a support system to new parents much like the extended family, but in a more professional way. In addition, as clinicians trained in family interaction as well as in individual psychodynamics, staff could assess the particular needs of each parent and the family as a whole, and offer referral to the appropriate service, whether that be a mother/infant group in the educational track of the PIPS program, or a family consultation or series of MIU sessions in the clinical track. Families could also be referred for individual or conjoint psychotherapy in other departments at Cedars-Sinai.

Although a detailed discussion of research findings would take us far afield, suffice it to say that a significant percentage of families in the experimental group availed themselves of various PIPS Services; 58 per cent used the Warm Line, and 25 per cent participated in the mother/infant groups. This is in sharp contrast to only 12 per cent of the control group who used the Warm Line and none who used mother/infant groups. It becomes clear that once parents became aware of services they did not have to struggle on alone with the myriad of anxieties facing them in the first critical months of the infant's life.

### *The Barr Family*

In all primary prevention practice, there have been many successful outcomes. The field of primary prevention is rewarding because the work is with young families in transition who are not usually invested in chronically maladaptive patterns. In many serious disruptions in familial interaction, major changes can be effected by even brief intervention which will alter the course of the infant's life and of the parents' life as well.

One clear example of this fact concerns the Barr family. This young couple was referred to PIPS by a pediatrician who was aware that the family was under great stress following the birth of their first infant. They had been married for 8 years prior to the pregnancy and were used to a comfortable routine. They had worked together in his accountant's practice and enjoyed a close, mutually satisfying relationship. The child, a daughter, was seven months old and totally unable to relate to anyone but the mother. She insisted on being held most of the time and even so was in a state of continuous irritability. She rested very little during the day and was awake several times each night. The mother was exhausted, emotionally and physically, and the father felt totally alienated from this mother/child circle of "oneness." Breastfeeding was used as the source not only of nourishment but of all comfort as well. By the time the family was seen they were desperate.

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[25] Brown, "*Parents are People Too,*" Foreword.

The first session revealed how the situation had deteriorated. The infant, though full term, had an extremely low birth weight caused by a problem with the placenta. The parents had experienced great anxiety about their daughter's survival. Jaundice set in soon after birth, and that condition, coupled with low birth weight, necessitated a prolonged stay in the hospital nursery. The parents' total energy, of necessity, was invested in the infant whose homecoming was marked by long periods of incessant crying and extreme irritability. Because of the weight and jaundice problems, it was critical to nurse her frequently, as often as every hour. This tied the mother to her infant more than is usual for breastfeeding babies. Father, at the outset, felt excluded from the mother/infant relationship and began to avoid interaction with either one. This situation continued unabated until the child was four months of age, when her weight progressed satisfactorily to the point where most of the anxiety about her health subsided. Mother then began to resent being the exclusive caretaker, but she was unable to extricate herself from the exaggerated symbiosis. However, not until the pediatrician suggested that she get help was she able to look outward for assistance.

Following the initial consultation, a series of eight sessions with the family ensued. Significant interventions were made in the interaction between mother and child, father and child, and husband and wife. Using the actual interactions of the family members, the social worker was able to effect significant change while the session was in progress. Outside of the sessions, dramatic changes also occurred. Use of the pacifier, supplemental bottles, and particularly soft cuddly toys all helped to give mother relief by enabling the baby to comfort herself. Mother became much more comfortable in encouraging her daughter to play independently by not responding dramatically to each whimper. More dramatic, though, was the change in the relationship between father and daughter. The therapist began the session by having the father hold his daughter for short periods of time even if she protested. Soon they were enjoying one another with great relish as the father gained confidence in his caretaking abilities. The baby's ability to relate to other than the mother was first transferred to her father and gradually to the therapist, to her grandparents and finally to a babysitter. Although mother, because of her own needs and the harsh realities of the infant's birth, may have been perpetuating this exclusiveness with her infant, her unconscious fears of losing her baby to others was unfounded, for in the early months of attachment the greater the number of figures to whom a child is attached the more intense is his attachment to mother as his principal figure likely to be.

Finally, and perhaps most important, progress was made in the interaction between husband and wife. The "coupleness" had become lost during the infant's first six months of life with father distancing from his wife who, in turn, felt abandoned with her difficult, demanding infant. Feeling alienated, father could not refuel her. The task for the therapist was to help restore at least some of the mutuality this couple once shared, for when disruptions of the mutual nurturing system occur it is necessary to help each member realize and express angry, anxious, guilty or sad feelings so that positive nurturing attitudes can reemerge. During the treatment period, as the infant began to function with less parental input and her ability to relate to others increased, the couple could begin to regain the closeness they once had, first in time spent with their infant and then in time without her. They practiced just being and talking together in the session, without permitting continuous interruption from the infant by encouraging her to play independently for appropriate periods of time. Thus, in a brief service modality, the equilibrium was restored in this family so that each had a comfortable place in the nurturing system.

### *Problems Still Unresolved*

Although primary prevention practice has evolved over the last ten years into several modalities of helping families with infants, there are still areas which need attention. Experimentation with different modalities enables clinicians to offer young families a number of options depending on their particular needs. The greatest concern is that of finding the time to offer families of infants, parent/infant rather than merely mother/infant groups. These must be in the evening or on Saturdays because most fathers are unavailable during daytime hours. Second, groups for single mothers with infants, whose issues differ somewhat from married women with infants, and evening groups for working mothers with infants need attention. Finally the issue of enabling couples to begin to consider what is ahead for them as a couple with an infant, *before* rather than after the actual birth remains a challenge. Attempts have been made to offer groups for expectant couples, but to no avail. It seems clear that their anxieties concern only the actual birth, and they are unable to look beyond this momentous event.

# SHIFTING THE FOCUS TO THE FAMILY IN RESIDENTIAL TREATMENT

*by*
*Christine A. McKenzie*

## ABSTRACT

This paper concerns itself with the experience of one residential treatment center in its shift from a traditional child-centered orientation to a family-centered treatment approach. The history of the center is reviewed, along with the factors contributing to the development of a treatment philosophy which views the family as the client. Included are a brief account of the evolution of residential treatment services; theoretical underpinnings which fostered the change; specific programs; initial outcomes; and future directions.

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Residential treatment centers apply a multifaceted, polyskilled team approach to the major psychological disorders of childhood.[1] It is within the therapeutic milieu that theories of individual development and psychopathology have been utilized in working with emotional and behavioral disturbances. Many treatment centers employ highly trained professionals to implement the various individualized programs for children. The thrust of residential treatment has been toward the child. Although family history was explored in understanding the development of a child's pathology, the family was most often not considered in the treatment process. This point may be argued philosophically, yet one need only examine treatment programs and treatment recommendations to validate the relative exclusion of the family.[2] Often, major therapeutic objectives were stated as resolution of intrapsychic conflict, development of insight and reorganization of the child's personality. The family rarely was mentioned. This was not intentional, for many factors contributed to the evolution of present-day treatment philosophies and methodologies which focus on the child as the client.[3] With recent contributions from family systems theory and research in residential care, the importance of family involvement has been demonstrated. Residential treatment centers must begin to modify their philosophies and programs in order to integrate developments which will enhance effectiveness of their service.

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[1] Joseph Noshpitz, *From Chaos to Order: A Collective View of Residential Treatment of Children* (New York: Child Welfare League, 1972), 2.

[2] This point is further discussed by Anthony N. Maluccio, "Residential Treatment of Disturbed Children: A Study of Service Delivery," *Child Welfare* 54 (1974), 232.

[3] A historical analysis of residential care is detailed in the following works: Hazel Fredericksen, *The Child and His Welfare*, (San Francisco: W.H. Freeman, 1957); D.M. Pappenfort, *Child Caring: Social Policy and the Institution* (Chicago: Aldine, 1973); Henry W. Thurston, *The Dependent Child* (New York: Columbia University Press, 1930); Alfred Kadushin, *Child Welfare Services* (New York: Macmillan, 1967); Emma Octavia Lundberg, *Unto the Least of These (New York: D. Appleton-Century, 1947).*

This paper details the shift from the traditional child-centered orientation to a family focused treatment approach in one residential treatment center. The history of this center will be reviewed along with factors contributing to the development of a treatment philosophy which views the family as the client. The specific programs for family involvement will be elaborated with consideration given to the barriers to change, the initial outcomes, and future directions.

## AGENCY BACKGROUND

Five Acres Boys and Girls Aid Society[4] was established in 1888 in Altadena, California, as a private, non-profit, non-sectarian, interracial agency for homeless children. The first significant program modification occurred in the 1930's when the agency shifted its purpose from that of an orphanage, offering custodial care, to a social agency providing residential treatment. This development parallels that of other children's centers; almost two-thirds of today's facilities for the emotionally disturbed initially served dependent and neglected children.[5] "Through increased knowledge of the way the human mind develops and functions, we have learned that children must be regarded and treated as individuals and that mass treatment retards the growth of personality, self-reliance and independence."[6] The program shift at Five Acres was a response to the incorporation of psychoanalytic concepts into mental hygience and social work practice and to the recognition of the importance of the "environment" in treatment.[7] The emphasis on the individual child within the therapeutic milieu encouraged a growth of specialized programs and a reduction in population to achieve a favorable staff-to-child ratio.[8] Currently, Five Acres serves children from age five to twelve who are found to be in need of placement and for whom institutional placement is indicated by factors of social adjustment, family relationships or emotional problems.[9] The average length of residence is 18 months.

Five Acres "...provides group care which is built upon the individualization of every child in the group."[10] Treatment services include: social casework; individual and group psychotherapy; activity/expressive therapies;[11] recreational therapies; psychiatric and psychological evaluations; nursing and pediatric services; parent and family counseling; parent education and support groups; and special education and related services. Each child has an individual treatment plan which is reviewed regularly by the treatment team to insure progress toward specified behavioral goals. A clinical social worker leads the treatment team which includes a psychiatric consultant, child care staff, the education director, activity therapy staff, and the representative of the placing agency.

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[4] Five Acres is a United Way agency and maintains membership in the Child Welfare League of America, the California Association of Children's Residential Centers and the Association of Children's Institutions and Agencies.

[5] D.M. Pappenfort and D.M. Kilpatrick, "Child Caring Institutions, 1966: Selected Findings," *Social Service Review* 43 (1969), 450.

[6] *Mary Irene Atkinson Speaking for Children*, edited by C.C. Jones and G. Springer (n.p., 1943).

[7] The concept of the "therapeutic milieu" was introduced by Bruno Betteheim and Emmy Sylvester, "A Therapeutic Milieu," *American Journal of Orthopsychiatry* 18 (1948), 191-206.

[8] In the past twenty years, the population served has been reduced from 150 to 48. The professional/child care staff-to-child ratio currently is 1:2.

[9] Five Acres manual, 4.

[10] Mary Lois Pyles, *Institutions for Child Care and Treatment* (New York: Child Welfare League, 1947), 12.

## DEVELOPMENTS LEADING TO CHANGE

That children should be raised in their own families has always been a central element in the Five Acres philosophy. Children come to Five Acres from families and are expected to return to families; yet, how this process is to occur has been redefined only recently in light of current knowledge regarding the family as a system. As a children's residential treatment center, Five Acres traditionally has assumed the role of the child's advocate. Treatment plans explicitly addressed the needs and best interests of the child. Subsequently, specialized programs were implemented, particularly in education and activity therapy. These changes and the basic agency philosophy toward treatment reflect a particular theoretical orientation which has dominated child welfare services for several decades. Yet, all centers must continue to reevaluate their philosophies and programs in the light of the current needs of the clients and the expanding body of knowledge that affects theory and practice. The following sections present the influences that have sparked the development of Five Acres as a family focused treatment center.

### *Emergence of Family Systems Theory*

"It has become increasingly evident that many of the conditions which lead to child dependency, neglect and delinquency can be dealt with constructively only through work with the family..."[12] This statement, made in 1947, indicates the growing awareness within the professional community of the impact of the family on the child. Theoretical knowledge of family systems was not available; yet, certain daring practitioners, suspecting important links between individual dysfunctions and family relationships, began "underground" exploration of their ideas.[13] The earliest conceptualizations of the influence of the family in the etiology of emotional disturbance were presented by Frieda Fromm-Reichmann in the 1940's. Her work in understanding the clinical symptomatology of schizophrenia focused on the role of the schizophrenogenic mother. The first consistent use of family therapy as a part of psychotherapy developed when Nathan Ackerman established the first family mental health clinic in 1958. During the 1950's, theories of family interaction and schizophrenia[14] and of family communication patterns of schizophrenic patients had begun to emerge.[15] Family theory continued to develop throughout the 1960's and 1970's under the influence of the writings of Bateson, Haley, Jackson, and others. The introduction of general systems theory by von Bertalanffy[16] also had impact on family theories. Today, many schools of family therapy have varying approaches and goals. All these notions have stimulated the professional workers responsible for residential treatment to examine their philosophies.

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[11] Art, dance, music and drama are generally considered expressive therapies. At Five Acres, the Activity Therapy Department includes activity, expressive, and recreational therapists.

[12] Lundberg, *Unto the Least of These,* 27.

[13] Murray Bowen, *Family Therapy in Clinical Practice* (New York: Jason Aronson, 1978), 185.

Family systems theory proposes that the family is an organized whole made up of mutually influencing parts. The family system can be understood in terms of its communication patterns, role relationships, and interactional patterns which are designed to meet the family's goals. Most significant is the notion that changes in one part of the system have effects on all other parts. This does not imply that other parts of the system change; it does mean that there will be a reaction. In most systems, the regulatory patterns serve to maintain the *status quo*. Therefore, change in one family member generally produces resistances and an ensuing struggle to return to former patterns, regardless of their functional value. Placement of a child out of the home often validates the family projection process[17] and actually discourages change within the family system. It is not unusual that the symptoms recur when the child returns on home visits. What, then, is accomplished? An expensive form of symptom relief for the famly,the school and the community? Salvador Minuchin recognized this problem in his researh project with the boys and families at Wiltwyck School for Boys .[18] Systems theory points to the necessity of dealing with the child's difficulties (excluding cases of organicity) as an expression of family dysfunction and therefore demands that attention be paid to the family system if substantial change is to be achieved.

## *Research in Residential Care*

Research on residential treatment is limited; most are descriptive, short term, or follow-up studies.[19] Practical information which can be applied to the improvement of programs via self-evaluation techniques or manipulation of treatment modalities is scarce. Although results often are conflictual, there are prevalent themes which substantiate the redefinition of the family as the client.

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[14] Murray Bowen and Theodore Lidz, "The Influence of Family: Studies on the Treatment of Schizophrenia," in *Progress in Group and Family Therapy*, edited by Clifford J. Sager and Helen Singer Kaplan, (New York: Brunner/Mazel, 1972).

[15] L.C. Wynne, "Communications Disorders and The Quest for Relatedness in Families of Schizophrenics," in *Progress in Group and Family Therapy*, edited by C.J. Sager and H.S. Kaplan and G. Bateson, et al., "Towards a Theory of Schizophrenia," *Behavioral Science I (1956), 251-264*.

[16] L. von Bertalanffy, *General Systems Theory* (N.Y.: George Braziller, 1968).

[17] Murray Bowen, op. cit.

[18] S. Minuchin, *Families of the Slums* (N.Y.: Basic Books, 1967).

[19] A. Maluccio and W. Marlow, "Residential Treatment of Emotionally Disturbed Children," *Social Service Review*, 46 (1972), 240-241.

An exploratory study at Bradley Psychiatric Hospital was concerned with variables affecting the child's outcome during treatment and later in his discharge environment. One of the most significant findings to emerge at follow-up was "...that in more of the cases in which the child was found to be living in a private home, rather than an institution, the parents had been seen at Bradley."[20] Certainly this suggested the importance of parental involvement and its impact on a child's post-discharge success.

In a 1973 study by Taylor and Alpert,[21] conditions in the post-discharge environment which supported gains made during placement were investigated. While the results of the study focused on support and continuity within the post-discharge placement, the findings also highlighted the positive role that parental contacts played in enhancing the likelihood of positive adjustment. Specifically, "the continuity provided for the child by contacts with his parents and contacts between his parents and staff was signficantly associated with adaptation in the post-discharge environment."[22]

The most recently published study which suggest a direct relationship between parental involvement and a child's treatment gains is the Edgewood Study.[23] Since 1964, Edgewood Children's Center in San Francisco has required that parents be actively involved in their child's treatment. Children also return home on weekends and for one month in the summer. Research findings indicated a strong positive association between the boys' adjustment at discharge and their adjustment at follow-up. It was the researchers' belief that "the factor most distinguishing the program from less successful ones is the ongoing involvement of parents."[24] Their findings "...strongly suggest that the more that parents are involved with their child in treatment, the better the gains sustained by the child at follow-up."[25]

### *Experiences at Five Acres*

Events and situations at Five Acres have also facilitated the process of change. Often, parents had been viewed as intruders. Their interactions with the child resulted in disruption of the child's equilibrium and hence that of the cottage and staff. A primary treatment technique was to distance the parents; yet, the avoidance of the dynamic interplay between parents and child proved ineffective in producing lasting change. Children who functioned well within the structure at Five Acres often were returned home only to re-enact the original behaviors presented at placement. News of such "failures" was disheartening and demoralizing to staff who had worked intensely with the child. Inevitably, questions were raised regarding the effectiveness of Five Acres treatment techniques as well as the premise of the treatment philosophy. Children could achieve satisfactory levels of functioning within the institutional setting. Methods would need to be employed to facilitate transfer and maintenance of that adjustment in the home environment. This would point directly to work with the family.

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[20] A. Davis, et al., "Effectiveness of Residential Treatment," *American Journal of Orthopsychiatry* 38 (1972), 472.

[21] Delores Taylor and Stuart Alpert, *Continuity and Support Following Residential Treatment* (New York: Child Welfare League, 1973).

[22] *Ibid*, 33.

[23] Genevieve B. Oxley, "A Modified Form of Residential Treatment," *Social Work* 22 (1977), 493-498.

[24] *Ibid*, 496.

[25] *Ibid*, 498.

The strength of the bond between parent and child also hinted at the significance of involving parents in the child's treatment plan. A previously prevailing attitude toward certain parents[26] of children in residential care could best be described as "Let sleeping dogs lie." Why attempt to involve parents who had so obviously rejected their child? And more importantly, why risk an additional rejection for the child? Again, the results of this approach proved unsatisfactory. The child had only the authority of staff on which to base his understanding of the attitude toward his parents' uninvolvement. This inhibited resolution of issues concerning the parents and therefore inhibited a child's ability to attach himself to another family. Some children were totally unwilling to accept another family. Their rejection was demonstrated by an increase of acting out behaviors[27] which jeopardized the likelihood of successful family placement, and in some cases, resulted in a transfer to a more intensive setting. Other problems occurred when the child was progressing in treatment and had attained some resolution of feelings regarding the parents. The natural parents would suddenly reappear requesting the return of their child. Regardless of the pre-placement relationship and the length of parental absence, the child willingly returned to the home. The program needed a means to validate the parent-child bond and to use it in treatment.

Not all parents were uncooperative or uninvolved. Positive working relationships were established with parents who eagerly supported the child's treatment plan and who actively sought counseling from staff. Visits with their child were consistent and provided current material for the child and parents to discuss in treatment. In these situations, the decision for a child's return was mutually agreed. Through active participation in the child's treatment, the family gained understanding of its dysfunctional interactions and had opportunities to develop more satisfying patterns. It was apparent to the staff that the child was re-entering a more supportive environment, which, as the literature has indicated, serves to enhance successful post discharge adaptation.[28] Given these observations of events, Five Acres became less willing to perpetuate the "band-aid" approach to treatment.[29]

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[26] Generally, these were parents who voluntarily or involuntarily placed their child desiring eventual reunion yet rarely visited. Often, these parents would "disappear" for months at a time leaving the child "in limbo" regarding his future. Physical abuse and severe neglect were also characteristic of these parent-child relationships.

[27] That is, a level beyond that generally displayed around termination.

### *Research At Five Acres*

In response to the ever-present desire to know the results of staff efforts, Five Acres conducted a nine-year follow-up study.[30] Data were gathered concerning the pre-placement, placement and current functioning of residents discharged from January, 1967, to December, 1975. An exploratory aspect of the research involved investigation of the nature of "success"[31] for former residents of residential care and the relationship of successful children to elements of the Five Acres program. During the period covered by the study, 207 children were discharged. The investigator was able to contact 119 of these 207. Seventy-four per cent of the contacted group were functioning within the community, in family settings or independently. Generally, results indicated that Five Acres program had been grossly successful[32] in facilitating a higher level of functioning for children who had previously been excluded from their schools, communities, and nuclear families at the time of placement. In the search for program variables influencing post-discharge adjustment, one of the more significant relationships was that successful children had parents who were involved with the agency social worker. This finding validated worker impressions and provided additional incentive to re-examine agency philosophy and policy regarding parents. These facts, in combination with other research and theory, also provided a more substantial base upon which to establish and implement policies which reflect shifts in treatment philosophy.

## PROGRAM ADAPTATION

### *Process of Change*

To address the issues of family involvement in the treatment program, a volunteer committee open to all interested staff was organized by the Director of Professional Services in the spring of 1978. The working committee consisted of the director, two social workers, the activity therapy director, and a child care supervisor.[33] Weekly meetings focused on agency philosophy and specific program modifications. The philosophy undoubtably established priorities; assessment of the existing service showed that the priority was the child. Some "lip service" had been paid to the importance of a child's family, yet staff had to admit that this was nowhere reflected in the program. Through continued discussions it became clear that a shift required more than the establishment of a new philosophy regarding the family. The shift in thinking would have to be implemented in all aspects of service from intake policies and procedures through allocation of staff time, parent visitation procedures, and parental interaction with all staff to discharge policies. The process of change was clearly as vital as the change itself.

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[28] Taylor and Alpert, *Continuity and Support*.

[29] This implies a covering up of the problem and a treatment of symptoms. It also indicates the type of treatment which some parents request; *i.e.*, "He's the problem, fix him." Treatment efforts which deal strictly with the child are analogous, in two ways, to band-aiding a serious wound: the treatment may work temporarily but problems will recur; and, with a serious wound, other parts of the body will require attention.

[30] Christine A. McKenzie, *"Residents of Five Acres,"* Pasadena, Ca., 1977. (Unpublished paper).

[31] Herschel Alt, "The Concept of Success in Residential Treatment—an Administrator's View." *Child Welfare* 43 (1964) 423-426.

[32] Without a control group, it is difficult to know how many children would have been successful without Five Acres program. The difficulty of evaluative research in residential treatment is discussed by Anthony Maluccio, "Residential Treatment of Disturbed Children," *Child Welfare* 53 (1974).

The committee spent many sessions working through its own resistances to the philosophic switch, since all members had been indoctrinated in the child-centered treatment approach. The discrepancy between stated philosophy and actual practice was highlighted by discussions centered on implementation of the family-focused programs. All committee members supported the proposed goals and programs, yet the addition of services to the family required re-allocation of social work staff time. This resulted in less time for individual therapy with the child. Staff recognized their reluctance to accept this change because it had become an agency "given" that all children were seen in treatment individually by a social worker. Commitment to a family model challenged this practice and required social workers to make decisions regarding the needs of the family and not exclusively those of the child. The committee's acceptance and management of its own difficulties and resistances to the proposed changes facilitated understanding of the agency's reaction.

Obstacles to change were predominantly attitudinal. Staff feelings toward parents, at best, could be described as cautious, since engaging the family was inviting additional conflict. Although most staff understood the intellectual arguments for parental involvement and, in many cases, could even empathize with the parents, a certain apprehension persisted. Alleviation of this concern came gradually as parental interactions increased under the supervision of the unit social worker and within the framework of the new program. Another signficant attitude was the traditional view that Five Acres was established for children. Their needs were primary and individualized therapies, as well as the milieu, were crucial in the resolution of behavioral or emotional problems. With increased familiarity with the notions of family therapy, all staff became more willing to accept new approaches.

## *Family Focused Programs*

Approximately one year after formation, in the spring of 1979, the committee's work was completed. A family-focused program had been designed which included significant changes in the intake procedures as well as the development of orientation, education and support groups for parents. Methods for increased involvement with the child on-grounds were also established. Five Acres would continue to treat children, yet the philosophy represented in the new programs validated the importance of parental involvement. The established policies acknowledged that the family was crucial, not only in the development of the child's dysfunction, but also in the remediation. Parents are expected to be involved weekly in some aspect of the treatment program.

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[33] Committee members were Bob Ketch, Gail Shaffer, Christine A. McKenzie, Joyce Meeker, and Mike Coleman respectively.

In order to reduce the propensity for the child to be viewed as the identified patient, an emphasis on the family as the agency's client begins at intake. Parents and placement workers are informed of the policy change on their initial contact. In the telephone interview, the issue of parental involvement is raised with the continuance of the referral process contingent on the cooperation and support of the parents. Cooperation and support can be evidenced in one of three ways: (1) a willingness to identify problems in the family and to participate in treatment programs; (2) a recognition of ambivalence regarding future goals and a willingness to work with Five Acres toward resolution; or (3) a decision to terminate the parent-child relationship and to allow others to provide such parenting. It is through the intake process that the family is introduced to Five Acres and its philosophy. Therefore, the intake tour and interview involves all family members. Both parents and the child are interviewed separately as well as with the family. An Art Therapy Family Evaluation may be utilized. During the family interview, problems are assessed and discussed in terms of the family system. Programs are presented in light of how they can help the family cope more effectively.

All parents are expected to be a part of the new parents' orientation group. In addition to engaging the parent in Five Acres, purposes of the group include: providing a more detailed introduction to Five Acres philosophy, programs, and expectations; acquainting parents with other staff and their specialties; continuing the assessment process; and providing a forum to discuss separation issues. The basic format is a series of short presentations on various topics followed by questions and discussion. The group is designed not only to present materials, but also to be responsive to the needs of those parents involved in the session. A social worker leads the group in four weekly sessions.

Two additional parent groups are offered. The education group focuses on teaching parenting and discipline techniques and on providing an understanding of childrens' developmental process and needs. In working towards improved family relationships, the group leaders encourage parents to examine family "myths" and to incorporate new communication skills and problem-solving techniques. Various methods are employed to convey information to the group. Didactic presentations are combined with audiovisual materials, group sharing, group problem solving, role playing, and assigned readings. Child development literature, S.T.E.P., and P.E.T. provide the basis for didactic materials utilized during the ten weekly sessions. Although adjustments in format may be made to individualize the needs and concerns of particular group members, the primary focus is on education. The arenas for personal issues and problems of parent are family sessions or group therapy.[34] Education groups are co-led by staff from the various treatment aspects of the program including social work, child care, activity therapy, or education.

The ongoing support group attempts to facilitate personal growth through mutual problem solving and group involvement. It also provides a supportive network for parents who often are isolated within their community, and perhaps their own family, due to their "problem" child. A member of the staff is the group leader, and is responsible for facilitating the group process. Groups may focus on special issues or populations. Issues might include termination, assertiveness or marital relationships while target populations could be single parents, adoptive parents, or blended families. Similar to the education group, the support group is held in ten-week blocks. Thus, groups' focus and membership may or may not change every quarter. It is possible that several support groups be held during the same quarter. The Director of Professional Services is responsible for coordination of the various parent groups within the program.

Milieu participation offers family members structured and semi-structured situations in which the family unit is acknowledged as primary in the child's life. Involvement may be such a specific, one-time event or outing as a birthday, or it may be such a planned interaction as an evening meal. This bridges the gap between the institution and the family and enables all participants to gain greater awareness and understanding of each other.[35] The activity therapy department also provides structured formats[36] in which families may experience each other in a fun, success-oriented manner. Activity therapists assist the family in "playing" together and foster increased communication and socialization skills. Cooking, sewing, gym, and woodshop are among the activity therapy modalities employed in work with families. Expressive therapists would utilize the modalities of art, drama, music, and dance. In addition to promoting the family unit, these sessions provide opportunities for role modeling by staff.

### *Initial Outcomes*

Integration and implementation of the new philosophy into policies and programs was a gradual process. As with any planned change, a major issue was resistance.[37] Time was essential in facilitating the shift in attitudes toward the new treatment approaches. Redefinition of staff roles has been difficult because the social worker had functioned as the child's primary therapist. With increased emphasis on a family model, the social work priority became provision of family therapy and case management of the child's treatment plan. Although individual therapy could be provided by the social worker, referrals also could be initiated to the expressive therapists in the activity therapy department. Expressive therapies had been utilized previously as adjunctive services. Therefore, the shift in primary providers threatened the established departmental relationships within the agency. The reluctance of social workers to relinquish the primary therapy relationship with the child has gradually diminished. The increased value on work with the entire family has contributed to the flexibility of staff in sharing treatment responsibilities.

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[34] Requests for individual therapy often are referred to local clinics or practitioners.

[35] This refers not only to parent-child relationships but also to houseparent-parent relationships.

[36] Formats include: (1) individualized family group, (2) multiple family group, (3) parents in child's regular activity group, or (4) community groups.

[37] Lester Coch and J. French, "Overcoming Resistances to Change," *Human Relations* 1 (1948) and R. Lippitt, et al., *The Dynamics of Planned Change* (New York: Harcourt, Brace & World, 1958.)

The new program raised agency expectations regarding a family's commitment to the treatment plan. This affected both admission and discharge policies. In the past, the agency accepted "workable" children. Now, the emphasis is on "workable" families. Initially, this additional criterion caused a drop in admissions. However, when referring agencies became acquainted with the new policy, this was no longer a problem. Procedures for discharge now include criteria related to the family's active involvement in treatment. Administrative support[38] was vital in providing the necessary follow through on these policies. The support was clearly demonstrated in the discharge of several residents whose parents refused involvement or otherwise subverted the treatment.

Unwritten agency policies regarding parental visitation had been set for at least one month to encourage the child's "settling in." The regular visiting pattern now begins within the first two weeks. Opportunities have been arranged to encourage parent contact, particularly on-grounds. One half hour before all groups is set aside for parent-child visits. Parents and other family members may walk their child back to the cottage after a campus or home visit.

The increased understanding, awareness, and acceptance of the new program emphasis enabled all staff to adjust their expectations of parents. An example of this development was the parents' orientation group. The first two groups were poorly attended. Several factors seemed to contribute. Coordination with other intra-agency services including family treatment or other groups was lacking. Parents were not given a clear, consistent message from the treatment staff. Also, at intake, the staff presented parents with expectations about their expected involvement; that is, there was a lightly stated invitation to participate, in contrast to a firm requirement in beginning the treatment process. An original eight sessions proved unnecessarily long and subsequently was reduced to four. Following exploration of these factors, a third orientation group proved very successful. Attendance held at 100 per cent for the four meetings, and parents gave positive feedback regarding the support of the group and their enthusiasm to be involved in future.

In summary, families are involved in the Five Acres treatment program. Parental responses to these programs have been positive. One support group remained together for over one year with minimal membership turnover. Staff schedules have been adjusted to include evening hours which enable increased contact with parents and families. Having successfully made the philosophic switch to a family orientation, workers are now seeking to improve their knowledge and skills in providing services to the family. Certainly, this is an ongoing process in which the entire professional community is engaged.

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[38] George A. Brager, "Institutional Change: Perimeters of the Possible," *Social Work* (1967).

## CONCLUSION

The importance of family participation within residential treatment programs for children cannot be ignored. "While the goal of parental involvement in treatment is pervasive as an ideal, the emphasis in most settings is on work with the child."[39] Five Acres has attempted to go beyond the ideal and to establish a program which emphasizes the role of the family. Theory, literature, and practical experiences have contributed to the development and implementation of family focused treatment services. Elaboration and refinement of family theory and techniques will continue to influence philosophy, policy and programs within Five Acres and other residential treatment centers. Evaluation of the effectiveness of these innovations in future follow-up studies is essential to validate the shift in treatment emphasis.

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[39] Anthony Maluccio and Wilma Marlow, "Residential Treatment," 236.

# AN INTERAGENCY PROGRAM FOR THE TREATMENT OF INTRAFAMILIAL CHILD SEXUAL ABUSE

*by*

*Ray E. Liles and David L. Wahlquist*

## ABSTRACT

Increasing numbers of cases of incest are coming to light in this country. The increasing number of newly reported cases is partially the result of communities developing specialized treatment programs and partially the cause of those resources being developed. In this paper an effort is made to state some of the underlying treatment assumptions of a particular treatment program and demonstrate how those assumptions have been related to the development of the structure of the program. The main aspect of the program discussed is interagency cooperation including both how that was developed and how it is related directly to service delivery. Some problems with this type of model are discussed and the point is made that in spite of some of the limitations this interagency model may be applicable to services related to problems other than incest.

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### *Introduction to the Problem*

Recent recognition that child abuse is more common than previously thought has as a parallel phenomenon the even more recent recognition that intrafamilial child sexual abuse, incest, occurs at a higher than expected rate. Weinberg[1] reported that the incidence of incest might be one or two cases per million population in the United States. However, Giarretto[2] reported that what began as a ten-hour week counseling program grew from 35 cases in 1971 to 180 cases in 1975 and was still rapidly growing.

There are several factors that have contributed to the recent dramatic rise in the number of reported cases of incest. The first, and possibly most important, is that specialized treatment has become available. It was previously believed that the incest taboo was sufficiently strong to prevent incestuous behavior, except in cases of psychosis or other unusual situations. In fact, the incest taboo has been strong enough only to prohibit people from acknowledging incestuous behavior, even to their therapists.

In families where incest had occurred, it was simply unthinkable to come forward for treatment. Victims who did attempt to disclose the behavior to an outsider were often openly disbelieved, called hysterical or vindictive, or perhaps considered to be unable to differentiate between incestuous behavior and incestuous fantasies. If a victim was able to convince the authorities that the behavior had occurred, the family was often destroyed by jailing the perpetrator (usually the father), putting all the children in long term foster care, and leaving the mother without husband, children, and in many cases, without livelihood.

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[1] Weinberg, S.K.; *Incest Behavior,* (New York: Citadel Press, 1955.)

[2] Giarretto, Henry: "The Treatment of Father-Daughter Incest: A Psycho-Social Approach," *Children Today,* 5 (1976) 2-6.

As specialized treatment became available, people began to feel that they had a place to go with their pain and confusion. The media exposure increased public awareness. At the same time, clinicians were becoming more open to the possibility that incest had occurred and was occurring. As social workers and others began to ask the right questions, families began to come forward for help. Self-help groups began to form, and many communities began to work with these groups in an effort to deal with the problem.

Another important factor in the increase of reported cases has been the changing operational definition of incest. Legally defined, incest usually includes the elements of "sexual intercourse" and "between blood relatives." In terms of personal impact, inappropriate sexual contact, whether or not it is actual intercourse between a child and a person in the caretaker role, whether or not they are "related by blood," is damaging. A victim can be equally as exploited by a step-father as by a biological father. It is the exploitation of a child by an adult for the adult's sexual gratification that causes damage to the victim and signals a disturbed family. Thus, the term *intrafamilial child sexual abuse* is more accurate than incest because it eliminates the spectre of supposed consensual behavior.

For the purposes of this paper, incest is defined as intrafamilial child sexual abuse, or sexual contact between a child and an adult within what the child perceives as a family relationship.

Several reports indicate that distressed populations, including adolescent runaways, adult female prostitutes, and adolescent girls in detention facilities have relatively high rates of incest in their backgrounds. Clinicians have reported that an increasing number of adults who enter therapy report incest in their personal histories. Incestuous experience is beginning to be recognized as a cause of intense and long-lasting emotional trauma.

Families who are in treatment because they have experienced incest dramatically demonstrate the interplay between individual psychopathology, family dysfunction, and community systems. Effective intervention for these families requires knowledge and expertise in treating individual, family, group, and community systems.

The purpose of this paper is to demonstrate how major human service agencies in a community can coordinate them to provide a coherent response to these intensely troubled families. By combining already existing resources, the community can treat families in a program designed specifically for their needs.

## RELATIONSHIP OF COMMUNITY AGENCIES TO THE TREATMENT PROCESS

A coordinated response to the disclosure of intrafamilial child sexual abuse begins with the initial handling of the report and continues through reunification of the family. Often several different agencies and many individuals will come into contact with a family that has experienced incest. It is vital that a consistent treatment philosophy be followed through the various stages of rebuilding that the family will experience.

During the development of the Riverside Interagency Sexual Abuse Council, a treatment philosophy based on the continual feedback from RISAC members, parents, and victims and from the work of other professionals and programs has evolved. The major elements of that philosophy are as follows:

Intrafamilial child sexual abuse occurs in dysfunctional families. Incest may represent a family's desperate attempt to keep itself together.[3] Informed consent of the victim is not possible. The victim is a victim even though he may not always feel victimized. The perpetrator is in an immature stage of psychosexual development. It is essential that he accept responsibility for his role in the family dynamics that allowed incest to develop. It is necessary for the perpetrator to absolve the victim of responsibility for what happened.

Many perpetrators, non-offending spouses and some victims prefer to avoid treatment. This program has demonstrated that the power of such agencies as the Department of Public Social Service, Juvenile Court, Criminal Court, the District Attorney's Office, and the Probation Department can be used to encourage people into treatment, and that these people will grow and benefit from treatment in spite of feeling coerced, angry, and resistant in the beginning stages. In addition, we support an aggressive investigation of the perpetrator by law enforcement and other angencies. A response from community agencies that indicates the gravity of the behavior aids greatly in the treatment of the perpetrator.

In addition, it is believed that reunification of these families is not only possible, but likely, given exposure to group, individual and family therapy, and participation in the self-help component of the program, Parents United.

The treatment that occurs between "client" and "provider" in incest cases is most efficient and effective when it takes place within the context of an organizational structure of community agencies specifically designed to deal with incest. During the past three years the Riverside Interagency Sexual Abuse Council has developed as such an organizational structure. RISAC is a group of professionals from various community agencies that provide services to families who have experienced incest. As part of an interagency program, these professionals contribute differing amounts of time each week and offer a variety of services which include: training sessions for the community professionals concerning the problem of incest; a central intake procedure to deal with cases recently reported; group therapy for child and adult victims, siblings of victims, perpetrators and non-offending spouses; assistance in developing the self-help group, Parents United; specialized social workers within the Department of Public Social Services who handle only sexual abuse cases; individual, couple and family therapy; case consultations with various agencies and professionals.

As RISAC evolved, participating professionals noticed that increasing numbers of families who had experienced incest were coming forward for treatment. It became clear that these families were coming forward not only because of a growing awareness in the community, but because there was the beginning of a consistent, helpful response from different community agencies. As the professionals from these agencies began to work together on a weekly basis to develop an interagency, coordinated treatment approach, it was observed that these families were becoming better able to survive the trauma of the report and remain intact.

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[3] Lustig, Noel, et al; "Incest, Family Group Survival Pattern," *Archives of General Psychiatry*, 14 (1966) 31-40.

The evolution of an interagency program to deal with a specific client population which had been well hidden in a community that did not have a great reputation for interagency cooperation was a process that took several years and is still continuing. It is worthwhile to examine how several of the major social service agencies in a community came to work together toward the common goals of protecting the sexually abused child and reuniting the family.

## DEVELOPMENT OF AN INTERAGENCY TREATMENT PROGRAM

The Riverside Interagency Sexual Abuse Council (RISAC) is an entity sponsored equally by three departments of Riverside county government: Health, Probation, and Social Services. It was formed in August of 1977 by a small group of staff representing the Department of Public Social Services and Children's Mental Health Services in the Health Department. The reason for the initial meeting was mutual interest in the problem of incest and treatment of the victims. Interest was kindled by what seemed like an explosion in the number of sexual abuse cases coming under Juvenile Court jurisdiction and awareness of a new and successful treatment program for the victims of incest and their families in Santa Clara County, California. It was determined that treatment of a problem of the complexity and potential scope of child sexual abuse would require many and varied resources. For this reason, representatives from the Probation Department were invited to attend subsequent meetings. In September, 1977, RISAC sponsored the first Daughters United Group; and in December, 1977, the first meeting of Parents United in Riverside County was held. The program has grown to 16 groups, including eight for adolescents and younger children, two for women sexually abused as children, and six for parents. Active membership in the girls and adult groups is more than 125. Because of this growth and because all groups have two professional leaders, RISAC staff has had to grow proportionally and now numbers 40.

In its early development, RISAC was faced with a legacy of distrust and suspicion among the agencies involved. Each plotted strategies to make certain that their interests were protected and that no other agency got too large a share of credit for what was being developed. Lack of understanding between agencies and even between different divisions within agencies is a commonly observed phenomenon. Reports at a regional meeting of people developing sexual abuse treatment programs in Southern California disclosed conflicts either within an agency or with interfacing agencies. Katz and Kahn[4] described the tendency of any group occupying a given segment of an organization to exaggerate the importance of their own function and to fail to grasp the basic functions of others.

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[4] Katz, Daniel. and Kahn, Robert; *The Social Psychology of Organizations*, (New York: John Wiley and Sons, 1966.)

In examining the history of RISAC from initial mistrust to a fully functioning organization, it is useful to examine the reasons for its successful development. An important factor is that there has been from the beginning a mutually agreed on goal which no single agency could accomplish alone. This goal has been the establishment of a treatment program for the victims of incest and their families. Continual reference to this goal has helped to maintain focus in times of organizational stress.

A second reason is that, unlike many councils and coordinating bodies, RISAC has a specific and clearly defined activity: that is, running a treatment program. Many coordinating councils and advisory groups spend a large part of their time reexamining their purpose, role, and reason for existence. This is rarely an issue with RISAC because there is urgent business at every weekly meeting.

A third reason for success has been the heavy participation of line staff. Line staff seem more production oriented (that is, accustomed to doing things themselves) than middle and upper administrative staff. Combined with line staff, however, has been enough experienced supervisory and administrative staff to maintain responsiveness to administration interests. Without administrative sanction and support, an interagency effort is doomed to mediocrity or outright failure. Groups which have attempted to establish similar programs without upper echelon approval and support are looked on with suspicion, attacked and frequently starved for resources.

Other factors in the growth of RISAC have been the stimulation and excitement of developing a program, including all policies and procedures, from the ground up. Those involved have had the opportunity to plan for and create a viable and needed service. Early involvement of the Riverside City Police Department has been a particularly important asset. Police were helpful not only in providing understanding of the legal and criminal justice system, but also in helping RISAC to avoid being perceived as one more "bleeding heart" community movement. Initially, the County District Attorney's staff was suspicious. Their concern was that RISAC wanted fathers left unprosecuted and that the program would eventually expand to include perpetrators of other sexual crimes, including child molesters. Careful program development, attention to maintaining credibility, and a series of frank exchanges of points of view has resulted in a close working relationship with the District Attorney's office. A deputy district attorney has been appointed to act as liaison with RISAC.

An additional reason for growth as an organization has been the novelty and stimulation of working with staff from other agencies. People from other agencies are seen in some ways as more interesting to work with. They speak a different language and are prone to see situations from different perspectives. Additionally, they are not the "same old faces" of day after day in the primary job.

It is obvious from the success fo RISAC that an interagency effort to treat the problem of incest is feasible, and that agencies can share manpower and other resources to develop such a program. RISAC has not created any new positions, and no requests have been made to the County Board of Supervisors for additional monies. An unusual characteristic of RISAC is that most staff are "volunteers:" they are not assigned to RISAC activities by their agencies, they have requested to work in the program. With this personal commitment, they seem to put out extra effort not only for RISAC, but for their own agencies as well. Generally, RISAC activity costs agencies little since most volunteers are told, in effect, by their supervisors "You can work in the sexual abuse treatment program if you continue to carry your regular duties."

The RISAC model is unique in several important ways. It is a method of creating a new program and treatment resource with no additional staff or financial resources. It can exist within and is compatible with already established agency structures. Most importantly, the interagency approach to program development is applicable to other problems and unmet needs.

## SELF-HELP GROUPS

The relationship between the Council and the two self-help groups, Parents United and Daughters United, can be precarious and strained. Basically, RISAC provides counseling staff for Parents United Groups, provdies agency and community training about the identification and treatment of incest and gives technical assistance and consultation to Parents United. Parents United Riverside is a chapter of Parents United in Santa Clara County. Members elect their own officers, raise money, provide support to members and schedule social activities. Most friction between Parents United and RISAC centers around who is in charge of the overall program. In fact, to be effective, there must be joint control.

Daughters United was created for the female victims of incest. Members group activities are largely controlled by their own group counselors. Parents United frequently provides money for girls' group outing and other Daughters United activities.

It is staff consensus that much of the effectiveness of Parents United is due to the program's self-help model. The self-help model has been used widely for a number of years to ameliorate specific conditions including alcoholism, drug abuse and obesity. These self-help groups have several features in common that contribute to their success:

1. Members can see in a concrete way that they are not alone with their problem. The presence of others is positive proof that they share the situation.

2. Members may feel that others who have had the same experience can more easily understand how they feel.

3. The term self-help indicates "do it yourself" which implies an active "nonpatient" role. Thus, participants expect to be active in coping with and resolving their own problem situation.

4. Group members relate quickly because they share the same situations and many of the same feelings. Senior members look after new members who "don't know the ropes" or who are in crisis. Through arrangements with the Riverside Police Department, senior Parent United members may meet and talk with families following an initial police investigation of a

report of incest. This early support during a period of crisis helps new families survive the crisis and ties new members into Parents United.

5. Self-help groups give members an opportunity to take leadership roles and to be assertive about the destiny of their organization. This is particularly important in dealing with incest perpetrators and spouses who tend to be passive.

Some concerns are commonly expressed by agencies and professionals about the use and effectiveness of self-help groups. Agencies many overtly or covertly work against self-help groups. They are suspect because they lack professional discipline, expertise, and depth. An issue of equal or more importance, but less openly expressed, is that professionals play a less important role than they play in other types of groups. Self-help groups can be difficult to charge or bill for and can be difficult to get agency credit for. Additionally, they often take credit when things work out well, and neglect to give credit to the professionals who work with them. A final issue is that self-help groups are not captive groups and tend to be less passive and more likely to challenge professionals when things are not working out well. All of these aspects can be frustrating and unrewarding for the professional.

RISAC has differentiated its role from Parents United by establishing that clinical issues are the special province of RISAC's professional staff. While feedback on clinical issues is invited from Parents United members, RISAC reserves the final judgment and control. Clinical issues are defined as those that pertain to group membership, topics to be discussed, group structure, group process and progress in the group.

Parent United elects officers, conducts its business meetings, raises money, keeps in contact with other Parents United groups, plans and schedules social events and provides a variety of support services to members and prospective members. Although these activities are the province of Parents United, RISAC staff is available for consultation on request. Communication and feedback between RISAC and Parents United is officially the responsibility of the Senior Advisor, a RISAC counselor who attends all Parents United meetings. This liaison role insures a continual flow of information between the two groups.

## APPLICATIONS TO OTHER PROBLEMS

Because it is the position of this paper that an interagency effort such as RISAC can be applied to other similar situations, its functions and structure will now be more closely examined.

To be successful, an interagency effort must have credibility from its inception. To start from a position of strength, it is helpful if the individuals heading the effort have already established credibility in their own departments. The more credibility they have, the more they can move into a project with limited initial supervision and control. Initial trust is enhanced by a continual feedback to individual departments by means of their respective participants. Areas of concern, of political consequence, and of potential conflict are identified in advance when possible. Also important in maintaining credibility is keeping mavericks out of the program. If they are included, they must be kept in a low profile, a difficult posture for a maverick.

Permission for activities should always be sought through proper channels in each department. Final approval of major actions should come from the highest level. Department administrators need to know what is happening to allay such concerns as, "What is that group up to?" Administrators can provide important support if kept informed, but generally dislike surprises. RISAC learned the importance of this early in its development when a wary Assistant District Attorney questioned the motives of RISAC and even its need to exist. The District Attorney asked the Chief of Police and the County Probation officer in a challenging way if they knew what RISAC was doing. Because they were aware of the program, they were able to answer and thus allay some of the District Attorney's concerns. Otherwise, the Council might have suffered a premature end.

RISAC was developed carefully and methodically. In the initial phase the program was not widely advertised, and every effort was exerted to avoid major mistakes. The concern was that initial mistakes might prove fatal to a fledgling, unrecognized program. Only after a period of proven success did RISAC and Parents United begin to "advertise" the program through pamphlets, community education, and the media.

Such interagency effort seems to have an inherent appeal in recruiting professional staff. One reason may be that the organization is run in a highly democratic manner. All positions have evolved from necessity and are staffed by those interested in a particular activity. All decisions of policy and procedure are debated and decided upon by the full staff. In the more than three years of existence, there has been no exception to this rule of decision by consensus. Decisions are made at weekly staff meetings which all members are invited to attend. One co-leader of each group is expected to attend every meeting. Each member has an equal voice in shaping organizational and clinical policies and procedures.

Another factor in growth has been that new members are needed and appreciated. The rapid growth has meant that on expression of interest, a qualified clinician is almost immediately accepted in the program. Most are brought in by current staff. Staff bring those they feel are good clinicians, will fit well into the organization, and can fill particular needs.

Although RISAC has used students, there are major liabilities. Students, because of their schedules, are often unable to stay long enough to be effective. By the time they are oriented to the program and the dynamics of incestuous families, and assigned to groups, they have only a short time before they must leave. Some students lack the clinical or personal maturity to cope with the problems of incest.

The majority of staff who helped to start the Council are still active. Considering the demands made on staff, this is remarkable. Possible reasons include:

1. Members are necessary to the program. Quite literally, it could not exist without them.

2. It is an organization that truly belongs to the members. The program could be terminated at any time if it were the desire of staff. No one would force program continuance.

3. Challenges continue. Problems and issues are constantly arising that

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require problem-solving skills and creative solutions. The organization has continued to have dynamic quality and proves continually stimulating to those involved.

The rapid growth of RISAC has created major organizational dilemmas. Those who enjoy creating a new program are not always those who are most interested in maintaining it. At times there has been a tendency to move enthusiastically to a new emphasis without giving due consideration to existing efforts. To overcome this, new members who get satisfaction from maintaining an existing program have been recruited and "assigned" responsibility for maintaining some existing functions.

The overall size of the program is straining the consensus decision-making and volunteer nature of RISAC to its limits. Attempting to make all program decisions at the weekly staff meeting becomes increasingly difficult. It is also a problem to monitor the effectiveness of staff and to be aware of what is happening in individual groups. Another problem resulting from increased size is the difficulty of orienting new staff. Basic orientation should include some understanding of the history and development of the organization. Staff orientation has been presented about every four months; it is therefore possible to work in the program for almost four months without formal orientation. With growth, more and more program details are slipping through the cracks. To counter these difficulties RISAC is, for the first time, considering a full-time paid coordinator. Although this is certain to change the character of the organization, it seems to be the only way to insure a large, well organized, clinically sound operation. It is planned that staff will continue to run the organization with the full-time coordinator doing their bidding. Only with this emphasis is there a chance of maintaining the unique and successful elements of the program.

## SUMMARY

As specialized treatment resources for intrafamilial child sexual abuse become available within communities, increasing numbers of incest cases come to light. These cases are complex due to the family and personal psychodynamics and the interaction of those dynamics with the socio-legal system within a context of strong social taboo.

Treatment of families who have experienced incest does not occur in a vacuum. It occurs within the realities of police departments, courts, social agencies, foster homes, mental health centers, and sometimes jail.

If families can receive treatment from the time of first report until reunification in an environment of consistency and understanding on the part of the agencies and professionals involved, the family will benefit enormously.

The program discussed in this account is an attempt to achieve that treatment process by means of interagency cooperation. It is worthwhile to note that the concept of redesigning the service system to fit a particular client group, rather than forcing the members of that group through an existing system, is one that can be applied to other problems, agencies, and types of clients.

# SOCIAL WORK PRACTICE WITH ASIAN AMERICAN FAMILIES

*by*

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*and*
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## ABSTRACT

Contrary to prevalent pessimistic views of family treatment of Asian Americans, this form of intervention can be feasible and effective. The reason for the appropriateness of family intervention with Asian Americans lies in the nature of Asian cultural values and norms regarding family structure and function.

With the intent of advocating and extending family work with Asian Americans, this paper explores: (1) the rationale for social work practice with Asian American families; (2) the cultural and structural barriers to engaging these families in treatment; and (3) clinical and nonclinical suggestions for practice. Issues of cultural relevance in practice and the danger of ethnocentrism are examined, and difficulties faced by bilingual, bicultural social workers are explored.

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Involving Asian American families[1] in social work treatment appears to be a difficult task considering the discrepancies between traditional Asian cultural values and the Western values inherent in family treatment. Emphasis on Western values of democratic familial interrelationship, self-determination, individual identity, and spontaneous interaction can encounter strong resistance from Asian American families who are rooted in a cultural emphasis on hierarchical family role structure, dependence on family, and control of emotional expression. Despite the differences in cultural value constructs, experience with Asian American families in three practice settings[2] indicates that working with families either in a modified family treatment approach, or in established therapy forms is indeed tenable and the treatment of choice.

With the purpose of demystifying and advocating family work with Asian American clients, the major objectives of this paper are:

1. to note indicators which suggest family intervention as an appropriate social work modality with Asian Americans
2. to delineate the difficulties of engaging Asian Americans in family treatment

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[1] "Asian American" signifies those of Chinese, Japanese, and Korean descent. The definition includes recent immigrants as well as first, second, and third generations. This study does not encompass Southeast Asians or Pacific Islanders although some findings may also apply to those groups.

[2] Los Angeles County/Asian-Pacific Counseling and Treatment Center, Asian American Drug Abuse Program, and Japanese Retirement Home.

3. to offer suggestions for overcoming obstacles and facilitating practice with this population.

## RATIONALE FOR FAMILY PRACTICE WITH ASIAN AMERICANS

In Asian American communities, there has been a steady increase in maladaptive behaviors including juvenile delinquency, substance abuse, neglect of the elderly, and mental illness. It has been hypothesized by Asian American scholars, community agencies, and community workers that family dysfunction precipitated by cultural conflicts is an important factor contributing to these problems. Practice experience also indicates that mental illness, substance abuse, and juvenile delinquency exhibited by Asian American clients reflect dysfunctional family systems caused by cultural conflict. Therefore, in responding to Asian American clients with these problems, the logical target of intervention is often the family rather than its individual members.

From a cultural viewpoint, the Asian values and norms which govern the structure and function of the family make family intervention particularly appropriate for Asian Americans. According to this traditional value system, the family rather than the individual is the basic socio-economic unit of society. An individual's self is defined through his family identity, and the welfare of the family as an unit takes precedence over individual welfare. The relationship between family members is characterized by a hierarchical role structure based on generation, age, and sex. The eldest male, either grandfather or father, has supreme authority in defining family goals and welfare. To carry out these goals as determined by the household head, great value is placed on family solidarity and cohesion, stressing the importance of interdependency and cooperation in attaining these goals. Instilling guilt and shame, and a strong sense of obligation to the family characterize cultural mechanisms to control behavior of members.

In the context of this hierarchical and interdependent family structure and function, the Asian American family can be viewed as a potentially significant source of stress as well as of support for individual members. Dysfunction in any part of the system affects the individual members more keenly than members of families of other ethnic groups whose emphasis on family cohesiveness is less. Thus, the whole family is likely to be in need of help and not just the identified client. Viewed from another perspective, the Asian American family creates stresses for its individual members by not acknowledging their right to independent pursuit of happiness, if such pursuit interferes with predetermined family goals. If a family member, through individual therapy or other influence, is able to make constructive changes, the family as a system may exert pressure on the individual to reverse such changes. Accordingly, modification in the family as a whole can be necessry to implement and maintain changes in the individual.

Just as the Asian American family has the potential to cause unusual stress for its members, it can also be a source of strong support. Because of a culturally instilled sense of obligation to one another, an Asian American family tends to be more invested in helping its members than are those families which place a higher value on individuality and independence. Family intervention can be a powerful modality in activating the family support system needed for members to cope with the stresses they encounter as members of a bicultural minority.

## BARRIERS TO FAMILY WORK WITH ASIAN AMERICANS

Although family work is an important treatment service in responding to the mental health needs of Asian Americans, several barriers prevent successful treatment. The first barrier is the stigma attached to mental illness. Because mental illness is viewed as shameful, Asian Americans are reluctant to seek services. Related to the cultural value of shame and pride is a high tolerance for mental illness, as suggested by Okano's and Chen's findings that Japanese and Chinese define mental illness only in terms of severe, overt symptoms.[3] Consequently, less conspicious behavior including neurotic symptoms, withdrawing behavior, and evidences of low self-esteem seem to be socially accepted and often are handled within the family.[4] Utilization of external resources occurs only in crisis when behavior cannot be controlled and is not amenable to family intervention.[5]

Second, conditions of service often discourage Asian Americans from seeking help. Inconvenience caused by distant location of mental health agencies, waiting lists, the necessity to make advance appointments, the rigid fifty-minute hour, and high fees keep some already reluctant Asian Americans from returning for help. Even when Asian American families in crisis do come in for treatment, there is a tendency for them to terminate as soon as the crisis ceases.

Another important barrier is the discrepancy between traditional Asian values and the goals, expectations and practices of Western therapists. In the established Western mode, the therapist is usually process-oriented and tends to emphasize insight formation along with encouragement of open communication. Asian American families value reserve and formality in interpersonal relations and are reluctant to communicate openly.[6] They tend to seek "concrete behavioral results" especially immediate eradication of symptoms and conflicts. The disparity in goals and expectations of the therapist and clients can lead to difficulties for which families tend to find solutions other than those set up by the therapist as part of the problem-solving process. The following is an example:

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[3] Peter Wei-teh Chen, "Chinese Americans View Their Mental Health" (Doctoral Dissertation, University of Southern California School of Social Work, 1976), 169.

Stanley Sue and Herman McKinney, "Asian Americans in the Community Mental Health Care System," *American Journal of Orthopsychiatry* 45 (1975) 163.

Yukio Okano, "Japanese Americans and Mental Health: An exploratory Study of Attitudes" (Doctoral Dissertation, California School of Professional Psychology, 1976), 253-54.

[4] Peter Chen, 163.

Harry Kitano, "Japanese-American Mental Illness," in *Asian America: Psychological Perspectives* edited by Stanley Sue and Nathaniel Wagner (Palo Alto; Behavior & Science Books, 1973), 193.

[5] Pei-Ngor Chen, "The Chinese Community in Los Angeles," *Social Casework* 51 (1970) 596.

[6] Derald Wing Sue, "Ethnic Identity: The Impact of Two Cultures on the Psychological Development of Asians in America," in *Asian Americans: Psychological Perspectives.*

> Mrs. Atami is a fifty-year-old Japanese widow who had lived in the U.S. for the last 20 years. She was seen in family therapy with her American-born, thirteen-year-old daughter who was having problems at school and at home. Weekly therapy had dealt with enhancing communication between mother and daughter and supporting mother to take authority for disciplinary actions which had previously been taken by the recently deceased father. Therapy was abruptly terminated after two months when the daughter was suspended from school and Mrs. Atami decided to send her to live with out-of-state relatives in hopes that a family environment would help her. This decision was made without consulting the worker. The mother lived alone then while the daughter spent the school year with relatives. Mother was seen once after the daughter moved away. Clinically, this type of separation may be anxiety producing to both parent and child, but mother denied any feelings of remorse or loneliness and saw her actions as the appropriate resolution.

## ISSUES FOR PRACTICE

In light of the aformentioned barriers to engaging Asian American clients in family work, social workers need to remain aware of two issues. One concerns the importance of cultural relevance in practice. The other is the danger of cultural ethnocentrism.

### *Cultural Relevance of Practice*

Social workers must understand the importance of ethnicity in the positive psychological development of Asian Americans. Giordano writes,

> ...ethnicity from a clinical point of view is more than a distinctiveness defined by race, religion, national origin, or geography. It involves conscious and unconscious processes that fulfill a deep psychological need for security, identity, and a sense of historical continuity. It is transmitted in an emotional language within the family and is reinforced by similar units in the community.[7]

Accordingly, the worker's respect for the value of ethnicity in working with Asian Americans will be an invaluable asset in the helping relationship. This awareness must be translated into culturally relevant practices.

### *Cultural Ethnocentrism*

At the same time, social workers, especially those who are bilingual and bicultural, need to be keenly aware of the fact that "normality" cannot be defined solely in terms of a cultural value system. Cultural values, whether of Asians or Americans, can be binding as well as nurturing. By dictating how a person or a family should be, cultural values and norms may cause misery to those who cannot fit into a particular mode of being. They can inhibit the individual and the family from valuing their own unique attitudes, behavior and needs. Further, in the context of multi-ethnic American society, the Asian American family's attempt to adhere rigidly to their cultural values and norms may rob them of the flexibility needed to respond to stresses which they encounter. The case example of Mrs. Atami and her daughter illustrates how culturally determined ways of solving a family problem can create a no-win situation.

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[7] Joseph Giordano, *Ethnicity and Mental Health* (New York: National Project on Ethnic Americans of the American Jewish Committee, 1973) 1.

Ideally, we need to help the Asian American family to become a more open, flexible system and at the same time retain the important values of their Asian heritage. In other words, social workers need to help them integrate the positive aspects of their heritage with those of the American culture. Asian values of communal family solidarity, responsible interdependency, and respect for others and the American value of basic individual rights are important growth promoting values which need to be integrated.

## PRACTICE SUGGESTIONS

In making practice suggestions, a presentation of approaches that accommodate to and confront culturally determined values, behavior, and defenses will be examined.

### *Non-Clinical Approaches:*

Because Asian Americans are reluctant to express themselves emotionally, approaches with families that respond to their emotional and communication needs without demanding that they verbalize such needs are often successful. This is especially important when doing outreach work in the community. Approaches successful because they are non-confrontive include: periodic conferences with parents to educate them regarding the identified client's problem and to suggest how to help the client; educational seminars for families at ethnic community agencies on current problems affecting Asian American families; and public conferences with speakers representing points of view of different family generations.

One program implemented in the Japanese community was for family members of elderly first generation patients suffering from Organic Brain Syndrome who had been placed in an ethnic nursing home. This program helped family members deal with feelings of shame and guilt associated with abandoning their responsibility for filial piety. Family involvement, as part of the overall therapeutic program, encouraged families to take an active role. Families carried out specific tasks which ranged from bathing their parents to planning and leading socialization sessions. Family Nights which allowed staff-family and family-family dialogues were implemented. This program helped the families to accept their own limitations and constraints in caring for their parents at home, thus reducing guilt, and to gain a sense of satisfaction by continuing their care. In this way, the program helped families to integrate the traditional value of filial piety and the

Western value of independence. Needless to say, this was also therapeutic for the elderly in whom we observed a remarkable decrease in depressive affect.

Multi-ethnic self-help family groups have been helpful for some Asian American parents. By identifying with the struggles of other parents, they are more willing to model after emotionally expressive behavior of others and to share their feelings in a supportive atmosphere. This can be useful in reducing parents' feelings of shame and guilt, and it is also helpful in disengaging the parents from excessive involvement with their children.

### Clinical Practice

The established process-oriented goals (for example: insight formation, improved communication, individuation of family members and subunits) and practice (including direct confrontation, restructuring family transaction patterns, working with the family as an unit, encouragement of intense emotional experience) of the existing modes of family therapy have been dismissed by some as culturally inappropriate for Asian Americans.[8] However, the process-oriented approach can be important in releasing the family's potential for responding to stresses created by their membership in two cultures. Thus the approach cannot be dismissed as culturally incongruent. In directing families to pursue process-oriented goals, the major challenge facing the worker is how to deal with their initial, culturally determined resistance.

The first step in handling the resistance is to develop trust. One way is to recognize the family's culturally different expectations and needs. Reassurance of confidentiality, provision of concrete services, home visits and outreach, flexibility in scheduling appointments, and accepting such cultural rituals as gift giving are initial gestures that indicate to the family that the worker is willing to provide what they need. Another way to develop trust is first to establish a working relationship with the identified client. Although some family therapists question the practice of seeing the identified client alone for an extended period of time, sometimes the only way to gain an entry into the Asian American family system is to let the family observe the successful progress of an identified client, thus testing the credibility of the worker and the therapeutic process without great risk on their part.

Attitudes and mannerisms of therapists can be crucial determinant in engaging Asian Americans in the beginning.[9] We maintain formality and authority by playing the role of an expert as exemplified in physician-client relationships. This meets the cultural expectation of the client for a structured, unambiguous interaction and forms a hierarchical relationship with the helper. This type of relationship can be important in engaging a reluctant family in therapy. With this authority established, the worker can demand, in a prescriptive way, that the family remain in therapy and work toward goals which may initially be difficult to accept. Furthermore, this hierarchical, expert-client relationship allows the worker to explore directly the presenting problems and uncomfortable areas including sexual matters in a matter-of-fact way, thereby reducing the family's anxiety. This authoritative position is emphasized in the initial phase or when the family threatens termination. Hierarchical relationships must be balanced with a sense of alliance and support as therapy develops toward more process-oriented goals.

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[8] Edward Kaneshige, "Cultural Factors in Group Counseling and Interaction," *Personnel and Guidance Journal* 51 (1973) 408.

[9] Hum Yun, "The Korean Personality and Treatment Considerations." *Social Casework* 57 (1976) 173-178.

Once the relationship is established, the worker can move the family into transforming its maladaptive structure and function by working toward appropriate process-oriented goals. In doing this, the worker once again capitalizes on his knowledge of cultural factors which have contributed to family dysfunction.

In the traditional, hierarchical Asian family structure, communication is channeled from top to bottom, from the head of the household downward. Accordingly, those occupying lower status in the hierarchy, namely wives and children, rarely have opportunities to voice their opinions and feelings toward those occupying higher status. This type of communication does not necessarily cause family dysfunction in families whose members all have strong commitments to a hierarchical family structure. However, the communication pattern becomes maladaptive when dysfunctional behavior of the household head (for example: wife or child abuse) goes unchallenged by the rest of the family. The goal of improving communication between the head of the household and those affected by his dysfunctional behavior becomes important: the household head must acknowledge the detrimental effect of his dysfunctional behavior on the rest of the family. Accordingly, the task of the worker is to create opportunities in the sessions for such communication. Ideally, such communication must be structured in a way that does not alienate the household head, who has the power to pull the family out of therapy. One worker used art to bring about successful, unoffending communication between an abusive father and his child:

> Mr. Kawata a 38-year-old Japanese businessman from Japan was referred by the court for evaluation after being charged for child abuse. During one session the son and father were asked to do a joint picture, then individual ones depicting scenes at home. In the drawing of the joint picture, the father's tendency to take over and control the son's actions was observed and was later interpreted to the father. In individual pictures the son drew the house with the father in one room, and mother, himself and his sister in another. The son, in describing the picture to the worker and father, was able to express his fear of his father, and why he preferred to stay with mother and sister. Father, on hearing this, seemed to be struck with awe, for this was the first time he had heard directly how his son felt about him.

In working with acculturated Asian American families with more democratic family structure and function, the worker can use less culturally sensitive approaches to improve communication and interaction. The following case illustrates the worker's use of a more manipulative and confrontive orientation in the style of Minuchin to improve transaction among family members.

> The Lee family consists of second-generation Korean parents and their two sons, age 18 and 11. The family came into treatment because of the 18-year-old son's excessive use of drugs. A triangular power interaction existed in this family with the mother controlling the father, the father dominant over the 18-year-old identified patient, and this son controlling the mother. The younger son played the role of pacifier and mediator. Because of her dissatisfaction with the marriage, the mother attempted to coalesce with the older son to exclude father. Her attempts further inhibited meaningful communication between the father and his son. In one session, the worker directed the mother to change seats so that the father and the older son sat closer and faced each other without having the mother in their direct view. The worker also asked the mother to remain silent until she was asked to speak. In other sessions, only the marital pair was seen in order to isolate the marital interaction from the parent-child one. Through these maneuvers and arrangements, the complicated triangular transaction pattern was blocked, thereby freeing the father-son dyad and the husband-wife dyad to engage in a dialogue uninterrupted by others.

In working toward solving the problem of intrafamilial conflict caused by cultural conflict, the worker may need to help the family better integrate American values by restructuring their traditional patterns of family transactions which are no longer adaptive. The following example illustrates how open communication between family members, the worker's aligning with a child subunit through role playing the child, and use of a co-therapist were helpful in achieving the goal of restructuring currently maladaptive hierarchical patterns of interaction into more adaptive ones.

> Family Park, a recent Korean immigrant family composed of parents, three teenage daughters and a younger son, was seen by a worker to respond to a conflict between the parents and the 17-year-old daughter. The father had recently begun to exert a great deal of control over this daughter for her being "overly involved" with a Caucasian boyfriend, who dropped out of her high school class. Two sessions were held involving the whole family. During the two sessions, open communication was encouraged regarding members' feelings about what had been taking place in the family. Such communication was facilitated by the worker's playing the role of an alter ego for the daughter. In role playing, the worker attempted to raise supportive, sensitive understanding of this daughter's inner dynamics by presenting her feelings of helplessness in being torn between two loyalties, her father and her boyfriend, which she masked well with her tough Americanized female act. The daughter began sobbing as the worker did this, which surprised the father and impressed upon him that something other than yelling and hitting her must be done.
>
> The worker suggested that the parents show more trust in her

> judgement and be less controlling. Detecting father's slight resistance to the worker, perhaps for being a young female, an older Korean male social worker already trusted by them was invited as a co-therapist for the third session to add validity to the workers' suggestions. Afterwards, the parents allowed the daughter to be more independent, thereby reducing the intense, violent conflicts between them.

Sometimes work toward gaining deeper self insight of the family members rather than merely a restructuring of certain behavioral patterns is needed to effect transformation of maladaptive functioning in Asian American families. Such work requires a long period of time.

> The Tanakas, a Japanese family, have lived in the U.S. for the past 10 years. They were referred for counseling because of the eight-year-old daughter's school phobia. Mother was seen in individual therapy while the daughter was seen by another worker, as it was felt that some of daughter's problems were caused by mother's overprotectiveness, high expectations and unresolved feelings towards daughter. Periodically mother, father and children were seen in family sessions. As a certain amount of trust began to develop after the first year, the worker guided her towards examining her anger and resentment toward daughter. The issues covered with the mother focused primarily around her anger toward her daughter for not being the outgoing active daughter whom she had dreamed of having. Mother had been shy herself, and without many acquaintances had hoped that her daughter would open opportunities for meeting other parents. Instead, mother had felt embarrassed as her daughter did not socialize with anyone. Mother's resentment toward daughter manifested itself in acting out problems at home where the parents were at a loss as to how to contain her behavior. Mother was retreating to harsh physical discipline and verbal threats which worsened the situation. Mother's increased insight into her own feelings regarding her daughter reduced her high expectations which in turn reduced her harsh disciplining.

In many cases like that of Mrs. Tanaka, we have found that Asian Americans respond well to insight oriented work as long as ample time is given in the beginning to build a solid foundation of trust.

## UNRESOLVED ISSUES

Little has been explored in terms of the problems and challenges encountered among bicultural/bilingual therapists who work with their own ethnic groups. Most of them received a Western education and must struggle to bridge the gap between the cultures and produce culturally adaptive therapeutic modalities. This is not easy, as these therapists can be limited by their own cultural restraints which are intensified when working with clients of their own group. Whereas an Asian therapist may not have a problem in utilizing a confrontive approach towards a non-Asian client, he may find it difficult to do so with an Asian American client because of the cultural atmosphere created in the interaction.

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This is not to say that a confrontive approach should always be used with Asians. However, it is important to note that there can be a fine line between being culturally sensitive and shying away from using confrontation. The reluctance to confront seems to come from the therapist's own discomfort in confronting a fellow Asian or fear of being rejected. This can be seen in the case of Mrs. Atami. When she decided to send her daughter away, the worker was disappointed at mother's decision. The worker, however, was unable to confront Mrs. Atami because of her cultural sensitivity and also because of her own reluctance and ambivalence to challenge the mother's traditional solution.

The unresolved issue raised here is how can ethnic therapists better deal with their own cultural countertransference towards Asian American families, and develop orientation and methodology which help them integrate the values of the East and the West. In addressing this issue, the use of co-therapists may be one way to develop more objective and effective practice. The practicality of this approach, however, is yet to be explored.

## CONCLUSION

Primarily due to the specific nature of Asian cultural values and norms regarding family structure and function, families of Asian American identified clients tend to play a significant role in the etiology and maintenance of clients' maladaptive behavior and self-image. Governed by these cultural factors, many Asian American families also possess a great potential for providing emotional and material support important for growth in multiethnic, industrialized American society. Given this dual potential to create and maintain stress and to provide support for their members, family work geared to minimize stressful elements and maximize supportive resources of the family seems to be an appropriate and often necessary intervention.

Although concepts and practice of family work are foreign to most Asian Americans, this intervention is workable and often indicated. For a successful application to Asian Americans, the worker generally needs to make the practice relevant by accommodating to culturally determined expectations, needs, and defenses. Yet at the same time, confronting and transforming these culturally determined attitudes and behaviors at appropriate points in treatment is often necessary to help the family develop into a more flexible system, able to respond constructively to the stresses they encounter.

# HELPING TROUBLED TEENAGERS IN BLENDED AND SINGLE-PARENT FAMILIES

*by*

*Josephine A. Jackson*

## ABSTRACT

As divorces multiply, increasing numbers of single-parent and blended families are seeking help from clinical social workers. The troubled children and adults in these families present special themes and life complexities which demand that the clinician develop a clear framework for therapy. Systems, communication, and learning theories are the base of the intense, directive, and often brief, therapy described. Family therapy is conceptualized as a point of view rather than a modality of treatment. The focus of change is interrupting dysfunctional interactional patterns; as new forms develop within the family, individuals have different subjective experiences. Stages of therapy and positive reframing are basic to family systems work; the adaptations of these fundamentals as well as the use of outside resources are described. Form and progression of therapy are presented, together with some aspects of strategy and intervention applicable to work with single-parent and blended families. Brief case material illustrates the use of this model of therapy.

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As divorce increases,[1] clinical social workers are seeing more families who live outside the traditional nuclear unit. The troubled teenagers and the adults in single-parent and blended families present special experiences and themes which must be considered during the treatment process. The first theme deals with fantasies about normality. Experiencing themselves as deviant from the cultural model, members imagine how relationships would be in a normal family. Such preoccupation maintains anger about the family break-up and gets in the way of dealing with the present situation.

A second theme centers around searching for guidelines. Such search often results in serial adoption of current "pop psych" trends: children's rights must come first; neither parent nor child should be limited in the search for self; freedom to do one's own thing is paramount. A watchful parent seeks outside assessment for what she anxiously labels "neurotic problems." Another parent accepts seriously deviant behavior as catharsis and justifies parental abdication of responsibility.

Another aspect is abrasion of the multiple life changes that intensify troubled situations. An uninvolved parent, angrily remembering past failures, is inaccessible. A weary parent is exhausted. An acting-out teenager is at risk with law and life. Members of non-traditional families have had heavy demands on their abilities to adjust. As a result, over-reactions to difficulties often intensify problems and limit options. Sensitivity to these reactions enables the clinician to respect what has been accomplished in shaping a family while assessing present limits to and further potential for flexibility.

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[1] In 1977 there were 1,090,000 divorces in the U.S.A; in 1978 the number rose to 1,130,000, and estimates indicate 1,170,000 divorces in 1979. *Peninsula Times Tribune*, 29 October 1980.

Financial problems frequently bring into the present the stings and battles of past losses and settlements. Monthly child support regularly rekindles feelings about such experiences. A single parent must either be employed or demonstrate gross incapacity to the Court. In fact, separation, divorce, and remarriage are costly life events which definitely affect the distribution and amount of spendable income.

A recurring issue in these non-traditional families is child custody. Natural parents, divorced when the child is four years old, may spend the next 14 years in custody litigation. A child has tremendous power to invalidate one parent when he chooses to live with the other. The peripheral parent is ever watchful for situations which might be used as levers for change. The child reverberates with parental struggles to work out sharing time on a 50-50 basis.

Respect for these themes, as well as understanding the current legal, social, and financial realities, are essential to the social worker who helps single-parent and blended families.

## CONCEPTUAL FRAMEWORK

Working with the complexities of non-traditional family forms demands that the clinician develop a clear theoretical framework articulated with treatment strategies and interventions. The author's search for such a conceptual base to practice began within an analytic orientation. While long-term analytic treatment resulted in individual growth, family dysfunction frequently increased. Exploration of existentially-based therapies (Gestalt, Transactional Analysis) maintained the emphasis on individual change. Increasing awareness of the persistent, inherently frustrating manner in which intimates often deal with each other led, finally, to training in the communication, interactional orientation of the Mental Research Institute in Palo Alto. Later training at the Philadelphia Child Guidance Clinic added important dimensions.

The clinical practice herein described is rooted in systems, communication, and learning theories. Family therapy is presented as a point of view rather than a modality of treatment. The family is a system of intimates; the individual is perceived as a part of many systems and subsystems. The work of Watzlawick and Weakland,[2] Haley,[3] Selvini,[4] Bowen,[5] and Minuchin[6] present the development and current formulations of this view.

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[2] *The Interactional View*, edited by Paul Watzlawick and John H. Weakland, (New York: W.W. Norton & Co., 1977.

[3] *Changing Families*, edited by Jay Haley, (New York: Grune & Stratton, 1971).

[3] Jay Haley, *Problem-Solving Therapy* (San Francisco: Jossey-Bass, 1976.)

[4] Mara Palazzoli Selvini, *Self-Starvation: From the Intrapsychic to the Transpersonal Approach to Anorexia Nervosa* (London: Chaucer Publishing, 1974).

[5] Murray Bowen, *Family Therapy in Clinical Practice* (New York: Jason Aronson, 1978).

[6] Salvador Munuchin, *Families and Family Therapy* (Cambridge: Harvard University Press, 1974).

Family systems therapy is focused on changing the dysfunctional patterns of interaction among family members. Haley writes that, "the main goal of therapy is to get people to behave differently and so to have different subjective experience."[7] Behavior, including presenting symptoms, is maintained by its consequences within the system. Troubled teenage behavior is a direct and metaphorical expression of adult difficulties. Dysfunctional, rigid interactional patterns which preclude effective parenting must be interrupted to remove the youngster from the role of symptom-bearer. Developing parental executive is the therapeutic process which begins the work with adult problems. Once the youngster is freed of the dysfunctional role related to adult issues, he has the opportunity to explore age-appropriate identity.

While it is possible to see only one family member (most likely one of the adults) and change the system, that treatment process is considerably more demanding of the therapist than involving many family members. The therapist must have a good deal of experience and sensitivity to extrapolate system interactions from the behavior and report of the one in the office. Strategy development, as well, is more difficult.

*Goals of Therapy.* Structural family therapy involves five somewhat sequential goals: (1) returning the executive function to the adult or adults; (2) facilitating effective functioning of the peripheral adult or adults; (3) marital or adult counseling; (4) return of the youngster to age-appropriate activities; (5) removal of the therapist from the systems.

Returning the executive function to the parents demands interventions which will early in treatment involve the adults in working out stances in which each is comfortable and can be sure of the other's support on the specific limits and consequences of the youngster's behavior. Previous efforts to achieve parental leadership have usually foundered on objections to one another's style of discipline or protectiveness of one's own child. The clinician must be active and skillful in avoiding rehearsal of past failures and engaging the adults in the presenting crisis. A single parent often needs the therapist's sustained support to begin thinking as a family executive. Again, the clinician's expertise must be focused on developing new structures that will provide relief from old, rigid patterns.

In non-traditional family groups as many as four adults may serve in parental roles. Typically, a natural parent is the one most heavily involved with the teenager; the other parent, plus step-parent or parents, have limited or peripheral connections. Working with all of these adults on behalf of returning the at-risk teenager to appropriate behavior must be undertaken with clear emphasis on the youngster's immediate needs. There must be, as well, respect for the legal, financial, and social realities. Given the highly charged feelings among these parental adults, the therapist must actively interrupt the blaming, putting-down, and other dysfunctional processes that have heretofore shaped the role of peripheral parent. Facilitating clear roles in effective leadership for the three or four parental adults in a teenager's life demands the utmost clinicial skill and creativity.

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[7] Haley, *Changing Families*, 283.

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As the strategies involved with the first two goals eliminate symptomatic behavior, it becomes possible to shift treatment focus directly to parental problems. The strategies, in fact, have begun the work on these difficulties and set the stage for further work with the adults, which may take the form of individual therapy or marital counseling. In the fourth stage, the teenager is supported in appropriate involvement with school and peers. Finally, the social worker facilitates termination with recognition of new interactional processes and by offering to be available in the future if necessary.

*Positive Reframing*. Minuchin describes positive reframing as reconceptualizing the symptom in interpersonal terms with appreciation of family members' efforts to make things work out well.[•] The therapist's ability to recognize well-intentioned efforts and strivings for family well-being can be forestalled by the search for evidences of repression, denial, projection and other aspects of intrapsychic dynamics. It is imperative to appreciate and identify positive motivations: controlling behavior may be expressing a strong sense of responsibility; parental threats can be an effort to protect; withdrawal from conflict may be concern for the other's fragility; and acting-out may be a demand for parental limits. Attribution of past failures to family procedures that have not worked both interrupts the search for fault and focuses on needed change. Such reconceptualizations, particularly regarding stereotypical ideation, facilitate new ways of thinking and experiencing in a family.

*Use of Resources*. The social worker's use of resources outside the family is designed to support the goals and progression of therapy. Alternative families often present situations in which the severity of the troubled behavior and limitations inherent in the unit present the need for outside help. Usually this help is invoked early in the treatment to strengthen the parental executive. A single parent who works evenings will call on relatives and friends for supervision. The mother of a 15-year-old son may plan to call a neighbor when there is physical abuse of siblings. In extreme situations the juvenile justice system may be the augmentation of parental limits.

The social worker plans with the family for outside contacts. Those made by the clinician are designed to focus the resource people on viewing and working with the parent or parents as executive. Occasionally, an appointment shared with family and resource person may be helpful to develop collaboration on behalf of the child.

When the youngster's acting out has precipitated consideration of removal from the home, the therapist must weigh the problems of placement and future family reunion against the presenting therapeutic difficulties. In several cases, the author has negotiated with juvenile authorities for trial periods of two months during which the family would have an opportunity to demonstrate controlling the teenager's unacceptable behavior. The resulting urgency to make changes and the threat of placement have successfully augmented treatment goals.

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[•] Minuchin, *Families and Family Therapy*, 53-56.

## FORM OF PRACTICE

Family therapy as a viewpoint rather than a modality indicates that decisions regarding structure are related to strategy development. In most cases, the first appointment includes the troubled teenager and both parents or the single parent, lover, or whoever is in the home and intimately involved with the family operation. Since the family is most concerned about and familiar with the symptoms, starting to work directly with issues of the troubling behavior evokes maximum cooperation. The clinician, meanwhile, emphasizes those aspects of her own personality and experience which are syntonic with the family; adaptations of language and communication style are essential. As the parent or parents describe the specific kinds of behavior that have been most upsetting, the clinician seeks for focus on the behavior that is troublesome to the adults, maintains the symptoms, is precisely describable, and occurs within effective parental function. For example, while a parent may long for a better attitude or more respect, these general terms are difficult to operationalize; cursing the parent or hitting a sibling can be focused on and dealt with. Forbidding smoking outside the home is usually unenforceable and, thereby, beyond effective parental function.

The adults are asked to discuss the details of limits concerning one bit of the youngster's troubling behavior. This discussion is therapeutic only if the clinician actively interrupts dysfunctional digressions. The adults must negotiate for authentic agreement on the limit-setting. Working out logical consequences of the teen's choice not to heed the limits must follow. The adults attend not only to the precise expectations of each other but, also, to the involvement of the other parental figures who may or may not be present in the interview. Issues such as the youngster's limits and adult enforcement must be communicated to and articulated with the work of the adults not present. It is essential to develop follow-through behavior for each adult as precisely as for the youngster's limits.

The social worker engages the single parent in the dialogue of identifying behavior for focus, defining limits, and setting consequences. The exploration for enforceable limits must often be expanded to consideration of resources available in the neighborhood and wider community. Again, planning the precise communication and involvement with the resources person is essential. The neighbor, relative, school dean, or probation officer are kept ancillary to the adult's executive function.

It is important, in working with non-traditional families, that the therapist be captured neither by parental feelings of helplessness nor by fine-sounding consequences that are unenforceable. These are the old patterns to be interrupted. Imaginative thinking is required to deal with such realities as work schedules and limited finances which are often cited as having prevented customary disciplinary actions. The clinician must be able to help the family distinguish discipline from punishment. While the former aims to develop inner controls, the latter inflicts pain and loss. Limits and their consequences are best shaped in the context of the youngster's making choices (that is, observe the limits or expect the consequences) and experiencing discipline that temporarily reduces freedom rather than seeks to inflict pain.

The importance of "turning around" family patterns in the first few weeks is underscored by the therapist's offering to be available by phone to any family member. In fact, there are few such calls except from single parents needing support and reinforcement of the prior treatment session. (When there are two adults, they often report the importance of their later talking about the session.) When the teenager phones, feelings are sympathetically responded to and the parental stance is supported.

A treatment contract is established at the end of the first session; this covers fee and agreement to work together for five or six weeks and may be renewed if appropriate.

The second week of treatment usually includes two appointments: one for the teenager to establish a treatment alliance; and one for the parent or parents to reinforce their working together. The entire family is seen together in the third week. In ensuing weeks the therapist elects to see different subsystems or the whole family. Individual work with the youngster is scheduled when the anxiety level, sense of responsibility for the family, and desire for change indicate that it will be useful. This work is focused on awareness and acceptance of feelings, taking more responsibility for self and less for family interaction, and exploration of choices and opportunities. It is established early in work with a family that material from interviews with individuals will not be reported to other family members.

After the initial successful use of the parental executive, there is usually a relaxation of adult leadership and a crisis ensues. Such crises offer opportunity to reinforce the directions of therapy. Later, as the youngster's troubling behavior subsides, the adults are encouraged to restore age-appropriate freedom as merited by the teenager.

Once the focus moves from the teenager's behavior, the adults continue their work on the problems that have impeded parental function. Occasionally, marital counseling brings to the fore consideration of separation. Such action is strongly discouraged until the symptomatic behavior is well-controlled. More often, marital counseling enhances the adult relationship. With the single parent, individual therapy involves work with feelings, exploration of choices, and the parent's taking more functional responsibility for family interaction.

Estimating the length of therapy is difficult. Many families terminate in two or three months when symptoms have subsided and limited adult work is accomplished. Some few families terminate at the first consolidation of parental executive. Extended therapy seldom involves the children once the troubling behavior is eliminated.

## THREE FAMILIES

The following case summaries are based on the intense, directive therapy described above. The human situations and the therapeutic interventions were much more complex than the described interactional changes would indicate.

*The Trout Family.* At the outset of treatment, Jim, aged 16, had been charged with mugging an elderly woman and was threatened with

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Court placement. Recent arrivals from the South, Mr. and Mrs. T and their four children were barely managing on lean finances. When anxious, Mr. T. stridently proclaimed his male rights to respect and authority. The more astute money and family manager, Mrs. T silently resented her husband's shouting, threatening, physically-abusing discipline of the children. She blamed him for the problems of her now-adult daughters by a prior marriage and their removal from the home by a court in Georgia.

From the outset of therapy, the parents' undeniable hard work and planning to improve the family circumstances were acknowledged. When they were first asked to negotiate mutually agreeable limits and consequences for Jim, the usual dysfunctional patterns arose. These included the husband's strident chauvinism, interruptions from the children, and the wife's empty, *pro forma* accord with her husband's ideas. As the social worker repeatedly interrupted these patterns, the parents cautiously moved to agreement on clear limits and consequences for Jim as well as precise follow-through for each adult. As the peripheral parent Mr. T was encouraged to assume daily responsibility for monitoring Jim's homework and other specific tasks. They worked out, as well, how Mrs. T would involve her mother (who was particularly close to and involved with Jim) in support of these boundries. Since the core issue of family dysfunction appeared workable, the social worker asked the Court to allow the family two months to control Jim's behavior; this request was granted with the proviso that financial restitution be made to the victim.

During the following three weeks, Jim's behavior was model, and the parents worked together as planned. In the treatment sessions, they discussed their feelings about these adjustments and developed agreements as needed. In the fourth week, when the high school dean phoned that Jim had cut school, Mrs. Trout retreated to her fearfulness about dealing with authorities. She called her husband at work and refused his demand that *she* follow through. Anxious about his work record as well as about Jim, Mr. T angrily left work, stormed the school, and beat Jim as soon as he was found. Distance and resentment between the parents resulted. Recapitualizing the crisis in the next treatment hour formed the base for reinforcement of therapeutic directions.

Jim was not willing to engage in individual therapy. Sessions were scheduled for either the parents together or for the family. They were seen once a week for two months and on alternate weeks for the next two months. Even with health insurance, this frequency was the limit of their finances.

Mr. and Mrs. T worked together on their feelings, on enhancing their relationship, and on difficulties with relatives outside the home. Jim completed the school year, repaid his parents for the restitution money by working part-time, and the parents came to view his and the other children's occasional acting-out as indicators of their needing to work together more closely.

*The Blythe Family.* Mrs. B divorced when Charles was 6 years old and had had no finanacial support from or contact with his father. Her long-term therapy had focused on her depression and withdrawal, her relationships with extended family and professional colleagues, as well as concerns for her son. After one and one-half years of weekly appointments, Mrs. B had terminated for two years, then returned to weekly therapy for two years. At 16, Charles had participated in two interviews when he had been charged with burglary. At that time, Mrs. B, who worked evenings, consolidated the parental executive with check-in telephone calls, limiting use of the car, insisting that Charles repay legal and restitution fees, and involving several men as back-up resources. Mrs. B's somewhat distant father and two colleagues, at her request, supervised and spent time with Charles. By agreement, the author contacted the Juvenile Probation Officer, discussed the situation, and urged specific support of the mother's executive.

Some time later, as Charles approached 18, he dropped classes and did not graduate from high school, was fired from his part-time job, and retreated during the days to their apartment. Afternoon and evening contacts with friends were maintained. Mrs. B was both sensitive to Charles's apparent ambivalence about becoming an adult and angrily worried about his withdrawal. She was, as well, acutely aware of feelings about approaching loss and loneliness and her own desire for freedom from the sole-parent responsibility.

Mrs. B's long-planned 3-week vacation became the focus for separation. After a 2-week absence from the office, the author was given an update on their situation: Mrs. B had begun to insist that Charles enlist in the military; Charles went to the recruiting office and then postponed the necessary steps to enlistment by sleeping in and "forgetting"; the mother angrily demanded action; Charles got a speeding ticket and precipitated other more superficial encounters with the police; Mrs. B became increasingly anxious about her son's immaturity and focused their interaction on his incomplete household chores. At this family developmental; crisis involving separation, the mother and son were "stuck" in the intense replay of their old dysfunctional patterns.

Mrs. B explored both her own ambivalence about the upcoming separation and the stances she could adopt toward enhancing Charles's growth toward maturity: she would not permit use of the car until the speeding ticket was settled; once Charles was 18, she would collect room and board money which she would bank for him until he moved out; she would stop doing his laundry and lending him money; she would let him know that she was no longer demanding that he enlist, since that had to be his own decision. As these issues were successfully worked out with Charles, Mrs. B decided to move out of their apartment and store the furniture while she was on vacation. Using the therapist's support, she made arrangements with colleagues and extended family to accomplish this move rather than depending on and arguing with her son about how he would help.

After her vacation, Mrs. B returned to find that Charles had slept one night in her car and had made decisions on his own. After helping his mother move into her one-bedroom apartment, he left for military basic training in another state. Before his first leave, he addressed her ongoing misgivings with letters enthusiastically reporting his new life.

*The Wallace Family.* Mr. and Mrs. W had been living together for four years and married for two. The family, including her eight and 10-year olds, had been joined by Mr. W's three teenagers. One at a time, George (aged 18), Jeffrey (aged 16), and Sarah (aged 13) left their mother. Mr. W, in middle age, was proud of his financial success although his profession took him away from home much of the time. Mrs. W, some 15 years younger, took total responsibility for the home and children. They agreed that problems arose out of Mrs. W's not having handled something adequately. In many important ways, each adult was peripheral to the children of the other; there were "her children" and "his children."

While the first appointment was scheduled after a volatile argument between Mrs. W and Sarah, Jeffrey was caught with a stolen bike before we met. Efforts to engage the adults in working together regarding Jeffrey's troubled behavior foundered on the father's wish to trust his son's ability to solve the problems. This alliance excluded Mrs. W and the therapist and also maintained Mr. W's peripheral role in the family. However, Sarah and her step-mother worked out some changes in their interaction in this first appointment.

In the following weeks, Jeffrey remained inaccessible, while Sarah used individual sessions to explore feelings about her natural mother (whose husband's nudity and drug use made her extremely uncomfortable), the pressures of being in the same school with Jeffrey who was acting the "tough guy," and her desire to compensate her father for his many hurts from her mother and brothers. Mr. W continued to hope that Jeffrey was solving his problems, despite signs to the contrary. He was willing to be engaged with Mrs. W in setting limits and consequences for the other children. In marital and family sessions, roles of each adult with the other's children were clearly addressed. Both experienced satisfaction in working together.

Therapy was interrupted when Mrs. W was confined to bed after an automobile accident. Mr. W became more central to the family; Jeffrey's school and home behavior deteriorated severely. In the first interview after the hiatus, Mr. W announced his disappointment in his son and his committed alliance with his wife. The parents' working together on Jeffrey's behalf was then clearly definable.

In the following month, Jeffrey was sentenced by the Court to a labor project which he completed with time off for good behavior. In a phone call after therapy was terminated, Mrs. W reported the family was continuing to meet and discuss issues and was enthusiastic about having so much energy now that the family was "working out." The family was in therapy five months.

# CONCLUSION

The complexities of working with troubled teenagers in single-parent and blended families demand that the social worker develop a clear conceptual framework for strategies and interventions. Thus firmly grounded, the therapist can be sensitive to the unique realities and experiences of the client group and can make the adaptations to practice that foster change.

The model of therapy presented is predicted on acceptance of a hierarchical family structure which respects individual differences. The family is seen as a system of intimates; strategies for interventions are developed from systems, communication, and learning theories. Dysfunctional patterns are interrupted to make way for more flexible modes of dealing with one another.

The presenting troubled behavior is seen as related directly to problems in the functioning of the parental executive. The initial thrust of therapy, as described, is to consolidate leadership with the adult or adults. In these non-traditional families consolidation may be complicated by the presence of a single adult or four or more adults. Restructuring these families demands articulating effectively the input of these adults in order to bring youngsters′ troubled behavior under control. This may involve the development of resources outside the immediate family group and clear strategies for their inclusion in the therapeutic process.

The clinician takes an active, directive role. While this therapy may be undertaken with only one adult client, more family members are usually included as strategies for change indicate.

# AN EXAMINATION OF TWO SOCIAL WORK TREATMENT MODELS WITH ABUSIVE FAMILIES

*by*

*D. Kinly Sturkie*
*and*
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## ABSTRACT

The Arkansas Alcohol and Child Abuse Demonstration Project established in 1978 has undertaken to identify and study 100 families in which there is simultaneous alcohol abuse and maltreatment of an adolescent and to test two family practice models. This paper presents an overview of the treatment models and preliminary findings with the first 65 families.

The premise of the generic family model is that the identified problem may best be treated directly through the family and its relational networks, since the abusive behavior represents the attempt of a system in crisis to stabilize itself. The Family Management Model considers a hierarchy of family basic needs, with abuse as a regressive response to life-threatening stress. Preliminary findings indicate that family therapy is effective in ameliorating the dysfunction which manifests itself in abuse of adolescents. Pending further research, practice with these families will continue to focus on improving the quality of marital interaction in order to differentiate the victimized adolescent.

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## INTRODUCTION

Although the disruptive effects of alcohol on the family have been noted for over three millenia,[1] and although the impact of alcohol abuse on the family has been a focal concern of social work practitioners since the inception of the profession,[2] it has been only in recent years that the full implication for the family system has been empirically examined.[3] The lack of systematic research on alcohol abuse and family violence is particularly interesting since the relationship between the two has long been established in folk wisdom, myth, and art.

In response to a growing awareness of alcohol related adolescent maltreatment, the Arkansas Alcohol and Child Abuse Demonstration Project (ALCAN) was established in 1978. ALCAN, which is affiliated with the Mid-America Institute on Violence in Families of the Graduate School of Social Work, the University of Arkansas at Little Rock, set as its principal missions:

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[1] Genesis 6:9

[2] Mary Richmond, *Social Diagnosis* (New York: Russell Sage Foundation, 1917).

[3] Jarry P. Flanzer, "Alcohol Abusing Parents and Their Battered Adolescents," *Currents in Alcoholism* VII, edited by Marc Galanter, (New York: Grune & Stratton, 1980) 529-538.

1. The identification and study of one hundred families in which there is simultaneously alcohol (ab)use and the physical, emotional, or sexual maltreatment of an adolescent, and
2. The field testing of two family-oriented practice approaches with this client population.

The purpose of this paper is to offer a brief overview of the two treatment approaches and to report preliminary findings based on the project's first 65 client families.

## RATIONALE FOR THE FAMILY APPROACH

The ALCAN Project was established with a basic family systems orientation for three reasons.

First, in recent years there has been an emerging realization that abusive behaviors — both substance abuse and child maltreatment — are less products of individual psychopathology than ecological problems which must be examined in context. Gelles,[4] Straus and Steinmetz,[5] Finkelhor,[6] and others have elaborated the constellation of biopsycho-social factors related to child and adolescent maltreatment, and Finlay[7] and Berenson,[8] among others, have identified similar factors in alcohol abuse.

Second, though homage has been increasingly paid in the literature to the need for "family" or "family-oriented" treatment, there have been few reports of successful conjoint treatment of abusive families. Furthermore, reviews of family therapy outcome research reveal no substantive studies undertaken with child or adolescent abusing families.[9] The family approaches were therefore employed to see whether or not they would stand up under rigorous systematic analysis.

Third, despite the destructive aspects of their family lives, most maltreated children who are removed from their parents either wish to return home or find themselves replaced there. Family approaches were therefore instituted to see whether or not treatment would allow the families to remain intact from the outset, in an attempt to decrease the trauma of movement and separation, as well as to decrease the economic costs of dividing and then reintegrating families.

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[4] Richard Gelles, "CHILD Abuse as Psychopathology, A Sociological Critique and Reformulation,"*American Journal of Orthopsychiatry*, 43, (1973) 611-621.

[5] Murray Straus and Suzanne Steinmetz, "Social Myth and Social System in the Study of Intrafamily Violence," in their *Violence in the Family* (New York: Harper and Row, 1974) 3-25.

[6] David Finkelhor, "Psychological, Cultural and Family Factors in Incest and Family Sexual Abuse," *Journal of Marriage and Family Counseling*, 4, (1978), 41-50.

[7] Donald G. Finley, "Alcoholism: Illness or Problem in Interaction," *Social Work*, 19, (1974), 398-405.

[8] David Berenson, "Alcohol and the Family System," in *Family Therapy*, edited by Phil Guerin (New York: Gardner Press, 1976) 284-297.

[9] See, for example, Alan S. Gurman and David Kniskern, "Research on Marital and Family Therapy: Progress, Perspective and Progress," in *Handbook of Psychotherapy and Behavioral Change*. Edited by Sol Garfield and Allen Bergin, (New York: John Wiley, 1978) 817-901; Richard Wells, et al., "The Results of Family Therapy: A Critical Review of the Literature," *Family Process*, 11, (1972), 189-207.

## THE ALCAN PRACTICE MODELS

Client families are referred to ALCAN through child and adolescent protective agencies and through components of the juvenile and adult judicial systems. The families are defined as abusive or neglectful in accordance with the relevant Arkansas statutes, though not all cases have been adjudicated. On referral the families are assigned to one of two treatment approaches. These are the Generic Family Model and the Family Management Approach. The Generic Family Model was implemented with the opening of the project in March, 1979. In January, 1980, the Family Management Approach was also implemented. Because most families have been treated according to the Generic Family Model, the findings reported relate to that approach unless otherwise noted.

### *The Generic Family Model*

The Generic Family Model's central premise is that adolescent maltreatment and alcohol abuse, though developed from and maintained through the complex interaction of systems at the individual, familial, and societal levels, may best be treated directly through the family and the relational networks it embodies. The model is based in family theory, the crisis literature, and other sources. Basic to the model is the idea that abusive behavior represents an attempt, albeit destructive, of a system in crisis to stabilize itself. Some crises which precipitate abuse are specific to certain families, but most are indicative of the family's inability to manage one of the developmental tasks which all families must negotiate. Abuse may be rooted, for example, in the inability to manage acquisition tasks which include the establishment of a new family through marriage, the birth of a child or children, the introduction of a step-parent. In chronically abusive families in which adolescent abuse is a temporal extension of ongoing child abuse, failures to manage the family's earliest acquisition tasks are frequently evident. Abuse may also be precipitated by a failure to manage developmental tasks associated with a loss such as the emancipation of older adolescents, the diminishing of parental control associated with the onset of early adolescence, divorce, single parenthood, or death. Situational abuse, especially that of adolescents not abused as children, often begins with the inability of a family to manage a loss, although situational abuse may also be associated with an acquisition task.

Principal goals of the Generic Family Model are to diminish and extinguish the "life-threatening" problems of physical abuse and problematic alcohol consumption; that is, to achieve and sustain systems stability without the use of abusive behaviors; and, to change those family transactions—both internal and between the family and the larger community—which have typically resulted in or contributed to an abusing sequence. In accordance with these goals, treatment is made up of two separate, though overlapping, phases. The first phase is symptom-specific, and focuses on the abusive behaviors; the second is characterized by a more general "growth orientation." Due to the danger of presenting problems, engagement and assessment processes are telescoped in favor of rapid intervention. Assessment is viewed as an ongoing process in both phases of treatment and is concerned as much with the family's response to a particular intervention as with elaborate problem formulation.

In the initial phase the worker is necessarily directive. He catalyzes rational decision making by restricting the expression of affectively laden material, by restricting family members to "I" statements as a way of thwarting scapegoating, and channeling all communications through himself as a way of controlling the mood.[10] Also critical in this phase is challenging the feelings of hopelessness which are typical of abusive families.

Early intervention must also emphasize maximizing and mobilizing family competence through the use of such traditional techniques as support, validation, and universalization and decreasing overinvolvement by facilitating family interactions with the community. Use of support groups such as Alcoholics Anonymous and Alanon is encouraged in families with severe alcohol abuse.

The techniques utilized in the second phase of treatment vary in chronically abusive families and in those in which the abuse has been infrequent and situational. In cases of situational abuse, during the second phase of treatment the clinician precipitates a crisis in the family while blocking attempts to re-stabilize by abusive behavior. In essence, he creates a situation in which problem solving is required while at the same time demanding the development of an expanded repertoire of problem-solving strategies. This may be accomplished with parents who are overinvolved with a triangulated adolescent, for example, by surfacing or precipitating a marital conflict and then blocking attempts to focus on the adolescent as a means of resolution.

With chronically abusive families the focus must remain on the maintenance of stability inasmuch as these families tend to remain in crisis. The techniques for maintaining stability noted earlier continue to be used throughout the second phase. In particular, a special effort is made to facilitate a systematic approach to problem solving. Whereas situationally abusive families tend to be rigid and constricted in their problem solving, chronically abusive families tend to be extremely chaotic. This chaos is manifested in the variety of symptoms which multi-problem families can exhibit. Identification and prediction of family crisis points, step-by-step walking through of problems, and rehearsing of responses all help to structure the family's problem solving. The panic and instability of chronically abusive families is contagious, and a *sine qua non* of treatment becomes the practitioner's ability to manage his own panic, fear, or apprehension.

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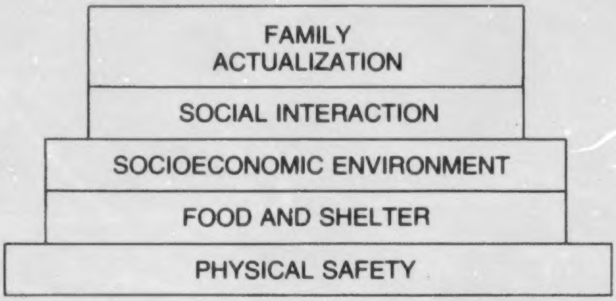
[10] Murray Bowen, "Theory and the Practice of Psychotherapy," in *Family Therapy*, edited by Phil Guerin, (New York: Gardner Press, 1976) 42-90.

***Family Management*** The Family Management Model's primary unifying concept expands Maslow's hiearchy of individual basic needs[11] to encompass the family. Family basic needs, as well as individual basic needs, may be set at a given step in the needs ladder; each basic "need step-level" is built on the previous one and supports the next. The "need-levels" are illustrated in this pyramid.



Families in crisis, facing problems of social deviance including problem drinking and child abuse, may best be helped by an approach that emphasizes balancing the individual needs of family members with those of the family as a whole. Family members must be able to establish their separate identities before true family reintegration may occur. This ability allows for bargaining from positions of strength.

All families in crisis, no matter what their problem, may be changing their members' functional interactional patterns.[12] These changing patterns reflect an adjustment down the need level scale; as the family regresses in response to "life-threatening" stress, it reverts to more rigid, structural patterns of basic needs.

Never is this more true than in the case of adolescent abuse and neglect, particularly when compounded by alcohol misuse. These deviant families are often caught in role confusion and intergenerational role reversals. Losing the battle to maintain functioning on a high level, these families begin to drop from one need level of functioning to a lower one. Family Management is initially targeted to stabilizing the family and stopping the downward spiral.[13]

Family Management represents an attempt to legitimize the clinician's activities in meeting basic human needs in preparation for ongoing psychotherapy. It is also an attempt to position the most qualified professionals on the front lines. Furthermore, it is an attempt to help the deviant, difficult cases which most treatment approaches avoid.

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[11] Abraham Maslow, *Motivation and Personality,* (New York: Harper & Row, 1954).

[12] Jerry Flanzer and Gregory M. St. L. O'Brien, "Family Focused Treatment and Management: A Multi-Discipline Training Approach," in *Alcoholism and Drug Dependence - A Multi-Discipline Approach,* Edited by J. Madden *et al. (New York: Plenum, 1977) 239-262.*

[13] Jerry P. Flanzer, "Family-Focused Management: Treatment of Choice for Deviant and Dependent Families," *International Journal of Family Counseling,* 6, (1978), 25-31.

*Treatment Process* The Family Management Model is composed of six distinct, but overlapping, phases: engagement, assessment, contractual, parallel relations, mutuality-negotiation, and termination.

In the engagement phase, basic immediate life-sustaining crisis needs are explored and met, and a helping relationship is offered. In the assessment phase, a diagnostic check list based on the hierarchy of basic needs and relevant functional and interactional patterns serves as the clinician's guide. During the ongoing contractual phase, contracts between clinician and individual family members and with the family as a whole are made. During the parallel relations phase, each member works on the contracted goals, while the family as a whole works on concrete actions to stabilize the family position. In the mutuality-negotiations phase, individual family members negotiate, "contract," and grow. During the termination phase, the treatment process and progress is reviewed and future plans are made.

## *Treatment Concerns*

The family basic needs concept may be used as a diagnostic-intervention checklist. Although basic, its tenets are often forgotten by the harried practitioner. Certainly the clinician cannot engage in higher level issues (for example, familial interpersonal communication) when problems arising from lower level needs (for example, active child abuse and alcoholism) are at stake.

A family whose functioning centers around a particular need level must have help geared to that need level; hence, the famous "beginning where the client is" has a particular operational-diagnostic meaning here: ..."beginning on the need-level of the client."

This treatment approach focuses on helping identified "family players" to label and assess personal needs and goals. The assessment *per se* leads to changes in the family balance because it encourages individuals to take responsibility for their own behavior and forces each family member to work at achieving a need-balance between his own development and that of the family. An assessment indicating where each family member is in the dynamic system will enhance the outcome. Clearly, the more individual family members who can be helped to reach autonomous goals consistent with the larger family goals, the greater the chance for system improvement. The clinician must assess the family as a whole. Each family member should be assessed as to where he fits in on the hiearchy of needs of the whole family. This assessment should be shared and jointly determined with the client. This approach is facilitated by having each family member assess his needs according to the scale to promote consistency among them.

The practitioner must work with the family to identify specific goals and treatment plans for the family and for each member. Emphasis must be on activity to reach the need level. The focus may be on job finding, rather than on feelings. This does not preclude a discussion of feelings which might support job finding. The structure is meant to enhance a focus on goals and on steps toward problem solving to realize these goals.

Contract between the clinician and family members must be based on a mutually agreed on assessment of need level and problem-solving steps. Full participation in the assessment process increases the likelihood of a successful contract. Specific time lines increase the contract's effectiveness. The process of making and breaking the contract can produce "grist for the mill" and often helps to highlight the determination of family members to maintain the *status quo*.

The social worker must be immediately concerned with the physical safety of individual family members when dealing with child abuse and neglect, as well as with alcoholism and problem drinking. Most clients of the demonstration project were initially at the lowest end of the scale.

The clinician must aim his primary interventions at the diagnostic need level. Operationally, this means that the worker cannot be developing interpersonal skills of the client when alcoholism is evident. It also means that outside professionals whose expertise fits specific need levels must be involved.

## THE CLIENT FAMILIES

Sixty-five families were referred to the project. Of these, four families did not meet project criteria, and 15 families were not seen by agency staff more than twice. Those families defined as not engaged included families who refused treatment, in some cases in contempt of court, and families who moved out of the catchment area (Pulaski County, Arkansas). The families who remained in treatment were seen for an average of seven months.

The racial distribution of the families was close to that of the catchment area, with 72 per cent Caucasian and 28 per cent black.[14] The sample was also appropriately representative of single parents, with 31 per cent in that category. The index used to measure social position showed that 64 per cent were in the lower middle or low range, 28 per cent were in the middle range, and only 8 per cent were in the upper middle or upper range.

Twenty-one families exercised their option not to participate in the research. Their non-participation may have biased the resulting findings.

## FINDINGS

Some of the project's preliminary findings have had an immediate impact on the treatment process (2,6, and 7 below). Others are neither fully understood as yet nor integrated into the therapeutic approaches (3,4, and 5 below). Following is a summary of certain of the project's findings. Unless otherwise noted, they are based on those 25 families who completed at least the pretest portion of the clinical measurement package.

(1) *Alcohol Usage.* Alcohol consumption in the ALCAN population was evenly distributed. Twelve parents were abstainers, thirteen were defined

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[14] N. Kalter, "Children of Divorce in an Outpatient Psychiatric Clinic," *American Journal of Orthopsychiatry*, 41 (1977) 40-51.

as light drinkers, four were moderate drinkers, and fifteen were heavy drinkers. Of the twelve abstainers, eight were the children of alcoholics.

(2) *Alcohol and Abuse.* No significant relationship could be found when comparing the parents' drinking level with the relative severity of the abuse or neglect of their adolescents. Heavier drinking does not necessarily mean more severe abuse or neglect. Alcohol intake does appear to determine *who* the perpetrator of abuse will be. The heavier drinking parents were found to have a significantly higher likelihood of being the perpetrators of abuse.

(3) *Victimization.* If a female was first born in a family, she was virtually always the target of abuse. However, birth order was not significant for the males.

(4) *Parental and Adolescent Attitudes.* No significant difference was found between the attitudes of perpetrators toward their abused and non-abused children, or in victims' attitudes toward their abusive and non-abusive parents.

(5) *Marital Satisfaction and Abuse.* An examination of sixteen intact marriages revealed no significant relationship between the degree of marital satisfaction and the severity of alcohol consumption or the degree of marital satisfaction and the level of abuse. Furthermore, the level of marital satisfaction was not found to be significantly related to which parent was abusive.

(6) *Family Therapy Outcome – "Hard Measures."* The Wilcoxon Matched-pairs Signed-ranks Test was employed to compare pre- and post-test measures of the degree of parental attitude change toward their adolescents for families who had participated in the Generic Family Model. Though no significant change in attitude was discerned for all parents, the perpetrators' attitudes toward their children improved significantly.

(7) *Family Therapy Outcome – "Soft Measures."* Of the 46 families who were "engaged," behaviors and disciplining practice defined as abusive were reported by the family members to have stopped in 22 cases. This finding is supported by the fact that none of these cases has been re-referred to the Family Center or the original referring agency for abuse. In seven cases, family members reported a reduction in the severity of the abusive behavior although it had not been halted. In another seven cases, there was no discernible change in the severity of the abuse. In none of the cases, was there an increase in severity.

In the remaining 11 cases, abusive behavior was halted, but not necessarily as a function of ALCAN's involvement with the families. In these cases the adolescent and his parents were physically separated at the time of case closure. These separations were both orderly and disorderly, representative of positive differentiation and dysfunctional distancing. For example, several families worked out alternative living situations with their adolescents which were acceptable to the ALCAN staff and the relevant judicial or protective services. One victim joined the armed services; another joined the Job Corps. These separations were viewed as both orderly and positive. Other adolescents were placed in state facilities for delinquents or were placed out of the home even though the families were in treatment. Though orderly, these separations were not viewed as positive. Two victims ran away. This was regarded as a disorderly and negative separation.

# CONCLUSIONS, IMPRESSIONS, AND A CLOSING CAVEAT

The preliminary findings of ALCAN are heartening: there are both "soft" and "hard" data to support the contention that family therapy is effective in ameliorating the individual and family dysfunction which manifests itself in adolescent abuse. *For the most part, these preliminary findings have not markedly changed the conduct of treatment.* However the research has clarified the staff's thinking.

(1) In families in which there are two serious symptoms such as physical abuse and alcohol abuse, it is often difficult for the worker to know where to begin. He may find himself oscillating between symptoms. Inasmuch as the severity of child abuse has, thus far, not been found to be related to the severity of alcohol intake, ALCAN focus is nearly always on the physically abusive behavior. In only a small minority of the cases has there been a pattern of severe abuse following heavy drinking. This supports earlier findings by Gil.[15] However, the ALCAN staff will focus primarily on the alcohol abuse when a particular client family "defines" alcohol as the principal, rather than as a contributory, problem.

(2) The Generic Family Model was based on the premise that adolescent abuse is often a product of an adolescent's being "triangulated" in an unstable marriage. By detouring the marital conflict through the adolescent and focusing on his inappropriate behavior, the couple can be relieved of having to scrutinize their own relationship. Preliminary research findings pose an interesting incongruity: though there is no evidence of a relationship between the degree of marital satisfaction and the severity of alcohol consumption, there is evidence that the Generic Family Model, with its focus on the functioning of the marital pair, is useful. Further research with a larger sample is being pursued in order to understand this seeming contradiction. In the meantime, practice with these families will continue to emphasize bolstering the quality of marital interaction in the service of differentiating the victimized adolescent.

(3) Though many families benefited from their ALCAN contacts, a serious unresolved problem has been the agency's inability to engage almost one quarter of the referred client families. The staff has focused on the development and use of techniques to deal with family resistance, and now believes that these engagement problems may be resolved only through more active involvement of the court. In child sexual abuse, a consistent finding has been that families rarely become disengaged or drift away from treatment when there is ongoing involvement of the judiciary.[16] ALCAN's position is that the legal system must begin to employ the same criminal sanctions in physical abuse cases that it has in sexual abuses cases in recent years.

(4) The ALCAN project was originally conceived as offering two forms of family treatment which would serve as substitutes for traditional child

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[15] David Gil, "Violence Against Children," *Journal of Marriage and the Family*, 33, (1971) 637-648.

[16] H. Giaretto, "Humanistic Treatment of Father-Daughter Incest," In Child Abuse and Neglect: *The Family and the Community*, Edited by R. Helfer and H. Kempe, (Cambridge: Ballinger Publishing Co., 1976) 143-158.

protective services. In many cases, however, ALCAN treatment services have run concurrently with, rather than substituted for, traditional casework services. Thus, the economic advantages of the family therapy approaches are yet to be established. Furthermore, it is unclear whether the family therapy would have been as successful without the other services. The issue of whether family therapy is merely an important ingredient in treatment or the treatment itself will continue to be examined.

(5) Diversity exists in the literature regarding who should be seen in meetings with abusive families: the family as a whole, the parent or parents, or other involved family members as well. The ALCAN treatment program was implemented with the belief that when adolescents are being abused, the entire family should have been seen from the outset. Early misgivings that including the adolescents might subject them to further abuse have been found to be unwarranted. The adolescents have shown themselves to be very capable of managing in the family meetings. At the same time, deciding who attends the meetings has occasionally been an issue more of circumstance and practicality than of theoretical orientation.

(6) Because of the limited sample of Family Management cases (six), it is not yet possible to make definitive statements regarding differential diagnosis and use of the two models with specific client populations. However, it appears that the Family Management Model may be more effective with chronically abusive families, whereas the Generic Family Model can prove more effective with situationally abusive families. The Family Management Model is better geared to stay at the lower "need levels" of the families than is the Generic Family Model which tends to focus on "higher level" social interaction.

(7) Though the ability of the Family Management Model to produce clinical change has not been demonstrated to the same degree as the Generic Family Model, experience with graduate students has proven it to be more prescriptive, more structured, and therefore easier to teach.

(8) Finally, the introduction of a change agent into the ALCAN families resulted in the eventual halting of abusive behavior in most cases. However, abuse did persist in some families. This finding is especially important for a "family oriented project," in which the maintenance of the family unit may take precedence over the protection of adolescents and their siblings. Social workers embarking on family treatment with abusive families must be conscious of the fact that maintaining or reconstituting the family, though important, is secondary to the protection of the child or adolescent.

# THE UTILIZATION OF SOCIAL NETWORKS: AN INTERVENTION APPROACH WITH THE MEXICAN AMERICAN FAMILY

*by*

*Margarita Prado-Borrego*

## ABSTRACT

The article discusses utilization of social networks while providing clinical social work services to Mexican-American families. Social network intervention is an approach to service delivery that involves significant individuals in the amelioration of identified psychosocial problems. Network relationships usually evolve from kinship, friendship, employment, ethnicity or whatever interests or elements people find in common.

Social network intervention takes into consideration both formal and informal systems that are involved in the life of the family. Also of significance to ethnic minorities is that this approach incorporates the socio-cultural components of the family. The utilization of support systems can be conceptualized in two main divisions:

(a) to engage existing networks and enhance their functioning

(b) to create new networks or "attach" a formerly isolated person or family to a network. The approach considers both the psychological and environmental stresses and incorporates the total reality of a family. Finally, the approach focuses on rallying the life sustaining forces of the individual and family. This viable system of self-help continues to function after the professional helper has disengaged.

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## INTRODUCTION

There is extensive literature regarding mutual aid and social networks. The Mexican American extended family and mental health problems in the Mexican American community have been the interest of many researchers.[1] Though the literature urges the involvement of the family and its support system in the provision of psychological and social services, writers do not address the issue of "how to" or the question of when it is appropriate to engage the social network when a practitioner intervenes with the Mexican American family.

This paper discusses social network intervention, an approach to Mexican American families that emphasizes the involvement of their networks of support systems and the effective use of these systems. Most families possess and utilize indigenous resources, such as *compadres* (co-parents), extended kin, friends, *curandero* (folk healer) and concerned others who are often overlooked by practitioners. In a rural setting, where few social and medical resources are accessible to families, the use of support systems assists in linking families with the appropriate agencies. These support systems are usually amenable to participating in the intervention process, and their appropriate role needs to be considered. It is also important that they are available even after the family leaves their linkage with the mental health agency.

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[1] R. Tuck, *Not With the Fist: Mexican Americans in a Southwest City* (New York: Harcourt, Brace, and Co., 1946); Margaret Clark, *Health in the Mexican American Culture* (Berkeley: University of California Press, 1959); William Madsen, *The Mexican American of South Texas* (New York; Holt, Rinehart and Winston, 1964).

## SETTING

The approach of social network intervention has been implemented in a rural community mental health setting in Tulare County, situated in the central San Joaquin Valley. Comprehensive mental health services are provided by the Kings View Corporation, a non-profit corporation that contracts with Tulare County. Dinuba Community Counseling Services, one of four clinics in the county, is the setting of the practice described. Located in the northeast part of the county, this area is predominantly Mexican American, with a total population of 27,500 and the main industry agriculture.

Since the Dinuba service area is a rural community, most of the social and medical services are located in distant urban centers, with transportation an issue for many families, especially because there is no public transportation system available.

## DEFINITION OF SOCIAL NETWORK

Pancost and Collins refer to networks as consisting of people and relationships.[2] The social network is a relatively invisible, but at the same time real structure in which an individual, nuclear family, or group is embedded.[3] The term support systems, as utilized here, parallels Caplan's conceptualization. He states:

> Support systems may be of a continuing nature, intermittent or short-term in the event of an acute need or crisis. Both enduring and short-term supports are likely to consist of three elements:
> (a) the significant others help the individual mobilize his psychological resources and master his emotional burdens;
> (b) they share his tasks; and
> (c) they provide him with extra supplies of money, materials, tools, skills and cognitive guidance to improve handling of his situation.[4]

This paper will delineate how a practitioner incorporates the various elements of the support system into an integrated approach. Case illustrations of Mexican American families will illuminate how social network intervention was utilized within a community mental health setting. The

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[2] Alice H. Collins and Diane Pancost, *Natural Helping Neworks: A Strategy for Intervention* (Washington, D.C.: National Association of Social Workers, 1976).

[3] Ross V. Speck and Carolyn Atteneave, *Family Networks* (New York: Pantheon Books, 1973).

[4] Gerald Caplan, *Support Systems and Community Mental Health* (New York: Behavioral Publications, 1974).

*implications for practice* will be discussed.

The term "social network" was first used in 1954 by John Barnes to describe the relationships of kinship and friendship in a Norwegian fishing village. His original definition of a network is still basic[5] Bott used the concept of networks in her study of working class English families. She observed, "The research families did not live in groups. They lived in networks, if one can use the term lived in to describe the situation of being in contact with a set of people and organizations some of whom were in contact with each other and some not." Bott defined network as the total relationship field of a person.[6]

Through the use of social network, mutual aid allows the opportunity for all networks in which individuals can be sometimes recipient and sometimes helper.[7] On the basic of what today is called "ethnological studies" Kropotkin proposed that cooperation and mutual aid are the very essence of the human condition.[8] Networks are one of the most viable bridges between the individual and his environment. Any individual's network is the sum total of human relationships that have a lasting significance in his life.[9]

Individuals usually belong to several networks at the same time. Networks can be based on kinship, friendship, employment, recreation, education, politics, ethnicity, religion or whatever interests or elements people find in common. The content of exchanges can also be varied.[10] Although the informal network is important, it cannot provide all of the family's needs. Formal resources (social service agencies, medical services, and other service providers) are likely to be utilized by families. Several researchers have concluded that support systems of the Mexican American family are primary in the provision of ongoing help and support to its members.[11] Borrego's research in the Central San Joaquin Valley on rural and urban Mexican American families concluded that the network of family and extended kin is a predominant source of support and assistance.[12] Casas and

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[5] John A. Barnes, "Class and Community in a Norwegian Island Parish," *Human Relations*, 7 (1954).

[6] Elizabeth Bott, *Family and Social Network* (New York: Free Press, 1971).

[7] Phyllis Silverman, *Mutual Help Groups: A Guide for Mental Health Workers* (Rockville, Md.: National Institute of Mental Health, 1978).

[8] Petr Kropotkin, *Mutual Aid: A Factor in Evolution* (New York: New York University Press, 1972).

[9] Collins and Pancoast, *Natural Helping Networks*.

[10] ibid

[11] E.G. Jaco, "Social Factors in Mental Disorders in Texas," *(Social Probems*, 194(1957)322-328; William Madsen, "Mexican-American and Anglo-Americans: A Comparative Study of Mental Health in Texas" in *Changing Perspectives in Mental Illness*, edited by S. C. Plog and R.B. Edgerton, (New York, Holt, Rinehart and Winston, 1969); Manuel Carlos *et al*, "The Mexican American Extended Family as an Emotional Support System" in *Family and Mental Health in the Mexican American Community*, edited by M. Casas and S. Keefe, (Los Angeles: U.C.L.A. Spanish Speaking Mental Health Research Center, 1978.)

[12] Rodolfo Borrego, "The Mexican American Family and its Support Systems." Unpublished paper presented at COSSMHO conference in Houston, Texas, October 1978.

Keefe suggest tapping existing networks in the Mexican American community when delivering mental health services.[13] Gonzales and Garcia found in their research that family members feel an obligation to help each other and actually do so in practice irrespective of class.[14]

Another significant indigenous resource is the system of *compandrazgo*. This system has its basis in the Catholic religion, whereby the relationship between the child's parents and godparents *(compadre)* is sanctioned through the ritual of baptism. This religious ritual reinforces an existing friendship and sense of responsibility.

The folk health care system is prevalent with some Mexican Americans. The literature identifies this belief system as a dominant source of help utilized by individuals of Mexican ancestry for the amelioration of mental distress and physical ailments.[15] For example, the *curandero* (folk healer) is a viable source of help and support. A *curandero* may be an individual of either sex sanctioned by the Mexican culture through its belief system. Consultation with a *curandero* is sought for physical and culturally determined folk illness such as *mal puesto* (hex, bewitchment), as well as other ailments. Help is rendered through prayer, rituals and use of herbs.

In recent times the research that documents a widespread use of folk medicine and belief in supernatural causation (such as witchcraft) has been criticized.[16] For example, Casas and Keefe argue that past investigation on this subject was mainly done among Spanish-speaking relatively unacculturated people with low levels of education.[17] Further, research in urban areas indicates that the folk belief system persists to some extent among lower class and Spanish-speaking Mexican Americans.[18] A recent study in Houston indicates that belief in folk medicine is not held by the majority of a random sample of urban Mexican Americans.[19] Current research questions the utilization of such a folk health care system among Mexican Americans.[20] It can be concluded from these paradoxical views that among some Mexican Americans the folk health care system is important and is utilized. For others, it does not play a pivotal role.

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[13] M. Casas and S. Keefe, "Family and Mental Health Among Mexican Americans: Some Considerations for Mental Health Services," in *Family and Mental Health in the Mexican American Community* edited by M. Casas and S. Keefe.

[14] M. Gonzales, and D. Garcia, "A Study of Extended Family Interactions Among Chicanos in the East Los Angeles Area." Unpublished master's thesis, School of Social Welfare, U.C.L.A. 1974.

[15] Ari Kiev, *Curanderismo: Mexican American Folk Psychiatry* (New York: Free Press, 1969); A.M. Rubel, *Across the Tracks: Mexican Americans in a Texas City* (Austin: University of Texas Press, 1966); M. Clark, *Health in the Mexican American Culture*.

[16] L. Saunders, *Cultural Differences and Medical Care: The Case of the Spanish Speaking People of the Southwest* (New York: Russell Sage Foundation, 1954); W. Madsen, *Society and Health in the Lower Rio Grande Valley* (Austin: Hogg Foundation for Mental Health, 1961); A. J. Rubel, *Across the Tracks: Mexican Americans in a Texas City*.

[17] M. Casas and S. Keefe, *Family and Mental Health Among Mexican Americans: Some Considerations for Mental Health Services*.

[18] C. Martinez, and H. W. Martin, "Folk Diseases Among Urban Mexican Americans" *Journal of the American Medical Association* 196, (1966); J.G. Bruhn and R.G. Fuentes, "Cultural Factors Affecting Utilization of Services by Mexican Americans" *Journal of the American Medical Association* 196, (1966); J.G. Bruhn and R.G. Fuentes, "Cultural Factors Affecting Utilization of Services by *Mexican Americans" Psychiatric Annals, 7, (1977)*.

Three questions identified in the literature will be addressed in this discussion.

1. How does a practitioner utilize the network of support systems when delivering services to a Mexican American client/family?
2. When does the practitioner reach out to the support system?
3. What are the advantages and disadvantages of involving a family social network in the process of providing help?

## APPROACH

Siporin writes that ecological perspective is an "effort to improve the functioning and competence of the welfare service system of natural self-help mutual aid networks, and to improve the social functioning and coping competence of individuals and their collectivities."[21] This approach calls for the practitioner to broaden his view of the client; it must embrace a comprehensive-holistic perspective. Intervention involves assessment of total social, physical, psychological needs when a client seeks help. The approach espoused here specifically suggests assessment of a client's network system; intervention calls for involving significant individuals who will assist in the amelioration of identified problems. In social network intervention, the goal is to deal with the entire structure by rendering the network visible and viable, and by attempting to restore its function.[22] The social network for Mexican American families may include extended kin, *compadres* (co-parents), friends, folk healer and other concerned individuals. These subsystems are identified because of their potential to provide emotional strength, support and other types of assistance to the family.

In summary, social network intervention emphasizes engagement of the family's network of support systems. The utilization of support systems can be conceptualized into two main areas which are:

(a) to engage existing networks and seek to enhance their functioning
(b) to create new networks or "attach" a formerly isolated person (or family) to a network.[23]

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[19] E.J. Farge, "A Review of Findings from Three Generations of Chicano Health Care Behavior," *Social Science Quarterly* 24, (1977).

[20] Frank Newton, *"The Mexican American Ethnic System of Mental Illness: An Exploratory Study," in Family and Mental Health in the Mexican American Community,* edited by M. Casas and S. Keefe. Robert B. Edgerton, et. al. "Curanderismo in the Metropolis: This Diminishing Role of Folk Psychiatry among Los Angeles Mexican Americans" *American Journal of Psychotherapy* 24 (1979).

[21] Max Siporin, *Introduction to Social Work Practice* (New York: Macmillan, 1975).

[22] R. Speck and C. Atteneave, *Family Networks.*

[23] Carol Swenson, "Social Networks, Mutual Aid and the Life Model of Practice" In *Social Work Practice: People and Environments: An Ecological Perspective* edited by Carel Germain.(New York, Columbia University Press, 1979).

The goals of this approach are achieved through mobilizing and employing support system for change. The intervention assists in "enabling people to cope and share their strengths in coping, and also to reap enjoyment and pleasure that restore their potentials and set them up to handle the inevitable next crisis."[24]

Three client situations illustrate utilization of their social networks. Participation of the social network in the amelioration of the problem and suggestions for implementing social network intervention are also presented.

*1. Tomas A.* The situation of Tomas A. and his family illustrates how the network of resources, that of *compadres, curandero,* and extended kin, were utilized in the provision of services. Tomas A. was an 18-year-old, single, Mexican American male brought to the clinic by his family (parents and two female siblings) and a *compadre*. The *compadre* was instrumental in referring this family. His familiarity with the community included knowledge of the agency's services.

Tomas exhibited behavior which was consistent with the symtoms of an acute psychotic episode. The family believed Tomas was "hexed" *(mal puesto)* by a woman with whom he had an amorous relationship. Their explanation of his psychosis was congruent with their cultural orientation and belief system.The precipitating stresses were unemployment and financial need.

Intervention focused on identifying the client, his family and social network as the unit of attention. Consultation with a *curandero* was supported in view of the family's definition of the problem. The *compadre* was utilized as the link between the family and *curandero*. Significant others were identified, their participation was encouraged, and psychotropic medication was prescribed for Tomas by the staff psychiatrist.

The initial meeting with the family and its support system revealed that the network was amenable to being involved in the intervention. Through observation and assessment of the interaction among members, information about their relationships was obtained. The intervention was structured to identify the individual needs of family members. Participation of extended kin, *compadres,* and friends facilitated the sharing of tasks. This provided an integrated approach. The tasks shared among members of the support system included provision of emotional support, food, money, and other commodities. Silverman refers to this type of interaction as mutual help whereby there is the opportunity for members to take each other's place within the structure of the network. Such role mobility within the network tends to foster competency in all participants and minimize a sense of weakness or incompetence in persons needing help.[25]

Tomas and his family were helped by their support system in the following manner: First, Mr. A., Tomas's father, was successful in obtaining employment with assistance from his brother-in-law who linked him with a prospective employer. Recommendation from the social worker provided additional support for his application for employment. Ms. A. was recruited by a *compadre* to provide babysitting services at a nominal fee, and finally, when Tomas's symptoms abated, he was referred to the Department of Rehabilitation for vocational training.

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[24] R. Speck and C. Atteneave, *Family Networks.*

[25] Silverman, *Mutual Help Groups.*

The involvement of Family A's informal network and linkage with formal resources helped them to accomplish several tasks. The primary task focused on restoring ego-functioning of Tomas and his family, thus promoting adaptation, competence and self-esteem. Also, the intervention was directed at improving transactions within the network to strengthen relationships. This family's situation required extensive professional assistance to coordinate and collaborate intervention efforts. In some family situations, the mobilization may require less professional intervention. The following family situation illustrates a minimal level of intervention.

2. *Rosa G.* Miss G., a 43-year-old, single, unemployed, Mexican American woman was referred by the Department of Public Social Services because of her "depression." Initial interventions included a psychotropic medication regime and outpatient group therapy, but little improvement was observed. With the client's permission, a home visit was made for further evaluation. During this visit it was learned that Miss G. was caring for her ailing elderly mother. She was facing an uncertain future, having no job skills and a slight facial disfigurement; hence, she was depressed. No amount of psychotherapy would change the realities of her situation.

With the client's consent, calls were made to her entire family and to her immediate circle of friends. Activation of the network resulted in freeing the client from her 24-hour nursing responsibilities so that she was able to begin to plan for her immediate future. She was linked to a community agency, enrolled in job training, and encouraged to reach out to her network. Her life situation changed once this was accomplished. Her network was also changed, in that its members were now taking on some responsibility for the mother and freeing the client. Natural healing is engendered when the client is linked with those most concerned. The two-pronged collaborative approach utilizing the client's social network and linkage with a formal agency resulted in success.

An active, goal-oriented approach with a supportive leadership role facilitated the involvement of the network system. When the client alone is seen as the unit of attention, information provided can be skewed and incomplete. As in Miss G.'s situation, the network was supportive and willing to participate. This had not been known previously. Intervention with her and involvement of her network resulted in new role definitions for both. She was faced with learning a set of behaviors appropriate to her new role. These new behaviors increased her self-reliance and ability to take charge of her own life.

Intervention emphasized the importance of linking her with her support system. Activation of her network mobilized its own internal resources, and this promoted constructive changes of benefit to all members. Her relationship with her mother was altered with others willing to share the responsibility of her care. More important, Miss G. was able to implement changes that improved her life situation.

3. *Orlando B.* The following family situation demonstrates how linkage with the social network influenced a client to remain engaged in treatment. A common concern among practitioners is premature termination by clients. Significant others may influence this process by making information available or by encouraging the client to remain involved. A related issue is the frustration encountered by the network in having to cope with a mentally ill individual.

The involvement of concerned family members can provide a link for engaging other members of the network. When Orlando B was initially brought to the clinic, he was accompanied by two relatives who were complaining about his bizarre behavior. On the other hand, Orlando, a 38-year-old Mexican American male previously employed as a farm laborer, complained of a head injury, insomnia, uncontrollable thoughts, and demonstrated bizarre ritualistic behavior. He requested "a cure" for his head injury.

For the purpose of engaging the relatives, their participation was supported, their relationship with the client was explored, and their perception of the client's problem was obtained. Their primary complaint was that the family could no longer tolerate Orlando, and they requested hospitalization.

Utilization of the system was aimed at deterring hospitalization for Orlando and providing support and guidance. The family was given information about how to relate differently with the client, their participation was encouraged and they became engaged. Intervention included Orlando's participation in day treatment, a program for acutely emotionally ill clients and a medication regime prescribed by the staff psychiatrist. Orlando's complaint of a head injury was ruled out after medical and neurological examination. He and his family were informed of the findings. Outreach efforts were made to extended kin, and sessions were scheduled to provide a forum for problem solving. These sessions, scheduled through Relative B who assumed a leadership role, accomplished several tasks:

First, alternative living arrangements with another family member were arranged to alleviate stress in Orlando's immediate family. Second, feedback about his progress was provided by family members and extended kin. Third, the meetings with all concerned provided an opportunity for implementation of a consistent behavior-oriented plan outside the clinic setting which enhanced the client's functioning and progress. Finally, the intervention had ripple effects on Orlando and his support system of family and extended kin. The system changed its expectations and its relationship with him. It ceased treating Orlando as "sick." However, it was noted that he resisted the change by considering dropping out of therapy prematurely. As he accepted and improved his functioning, he was able to change his expectations and relationship with his support system. His role changed from that of total enmeshed dependency to that of semi-independent functioning.

Outcome of the intervention was that Orlando's condition stabilized and he returned to farm labor work on a part-time basis. As his relationship with his family members improved, he had less contact with the clinic, and then he and the network terminated their involvement with the agency. Several months later, Orlando returned; however, this time he requested help. With this difference the client was more amenable to intervention, and the family knew the agency and the worker who would help them.

This family situation illustrates how a community mental health setting was viewed as a resource instead of a place for "crazy" or "sick" individuals. Concomitantly, a client's network served as a resource for the service provider by implementing a therapeutic plan outside of the clinic setting. In the B. family, the network provided transportation, a wealth of information about the client and his network of relationship. Their support and cooperation helped him to remain engaged.

## SUMMARY

The case examples illustrate how social network intervention was implemented. The approach considers the individual's psychological, physical and sociocultural needs and suggests involving significant others. The emphasis of the intervention was holistic, in contrast with a reductionist model which takes the individual as the unit of attention.

In the three case illustrations the roles of the social network members were varied, based on the needs of the identified family. Specific to a rural setting where resources are scarce, the social network was a viable link between the family and formal agencies. For example, members of the network provided money, transportation and other services. Finally, the social network was available to provide on-going emotional support after the professionals disengaged.

There are three phases which describe how social network intervention is conceptualized. The following discussion recapitulates these phases: assessment, planning, and intervention.

*Assessment* The social network approach assesses an individual as an integral part of a succession of open systems, each of which is a subsystem of a larger unit. Assessment is based on a broad view of the strains and maladjustments of levels of the client systems, subsystems, and individual. The "problem" is viewed as a lack of fit between the coping capacities of the person and the qualities of the impinging environment.[26]

The practitioner's awareness and sensitivity to the Mexican culture is of paramount importance. However, recognition of the fact that not all Mexican Americans are knowledgeable about and able to utilize indigenous resources is important. The practitioner must identify what is important to a particular Mexican American family, which needs are verbalized and which are unexpressed, and informal resources which exist within the context of its social network. Identification of the strengths of the network's individual members and how these can be incorporated in the amelioration of the problem is vital. Another consideration is to recognize other agencies or formal institutions involved in the life of the family.

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[26] Caplan, *Support Systems and Community Mental Health*.

*Planning*. After thorough assessment, which includes gathering information about the family's social network, the practitioner must decide how to implement his intervention plan. At this point, inclusion of paraprofessional staff or assistance from members of the clinical team is considered. Willingness to use the expertise of other staff members is important. Assignment of roles is based on the needs of the particular family and the expertise of staff; for example, if a family speaks only Spanish, this clearly indicates that all those in the session must be able to speak Spanish.

In planning, consideration must be given to where and when the session will be held. This decision is based on what is most feasible and strategic. Home visits are appropriate and provide information about the family's natural setting. Also, they are a method of outreach which may provide favorable results in attempting to include significant others. If a family agrees to come to the clinic, the issue of transportation needs to be considered prior to the meeting. Available transportation is an issue that may influence a family's participation.

*Intervention*. Social network intervention seeks to clarify the nature of the environment. Consideration is given to relationships between persons and objects in the environment as well as environment and persons. The units of attention are the family, the client and significant others.

The role of the practitioner is an active, goal-oriented approach with a positive view about the social network's strengths and potential. Social network intervention is teamwork with the practitioner as case manager, to provide direction, to coordinate and collaborate with members of the units of attention and formal agencies, where appropriate.

Working with the Mexican American family requires understanding of family theory, familiarity with socio-cultural components, and knowledge of community resources. Basic social work skills are important; however, the practitioner must be willing to widen his lenses through the phases of intervention. Recognition that it takes time to mobilize a social network needs to be acknowledged.

Implications for social network intervention with Mexican American families propose that its use be seen as an integrated holistic approach. The most effective model may be neither the formal caregiving system nor the natural network operating independently, but rather both working together and utilizing the capabilities of each. This approach considers psychological and environmental stresses and incorporates the total reality of the family. Of significance to an ethnic minority such as the Mexican American is that it incorporates socio-cultural components often overlooked by practitioners. Also, the social network is a supportive force that encourages a particular family to remain in therapy after the acute stress has subsided. Finally, the social network is the life-sustaining community within the social matrix of an individual, available after the professionals have disengaged. Their participation may range from reinforcing growth and development of relationships to assisting in resolving problems and providing ongoing support.

*Disadvantages.* Although this approach has promise for family practice, there are situations in which the social network may not be available.

For example, Anna C., a 35-year-old Mexican American divorced woman, was diagnosed as schizophrenic, chronic type. She was the mother of four children who had been removed from her custody and placed with relatives. Efforts were made to involve the social network; however, members of her network sabotaged intervention efforts, rejected the client, and were basically uncooperative. In such a situation, consideration must be given to exploring alternative systems which may provide a more constructive environment. Not all social networks are supportive of clients, nor do they cooperate with social workers.

### *Unresolved Issues*

Despite the potential of social network intervention with families, there are unresolved issues in the provision of services. The first issue is the element of time. Since social network intervention requires more time per case than "office bound services," how should time be allocated? Social network intervention requires time for intensified outreach efforts by mental health providers. A practitioner who works with families and uses this approach will require time for collaboration, coordination and follow-up. Second, is the approach primarily an intervention for multiproblem family situations, chronic mentally ill or poor minority families? Third, does social network intervention imply a philosophy of intervention that requires agency sanction for effective implementation? Finally, are agency resources such as mileage for field visits and billing for phone and collateral contacts available to support this approach?

These issues must be addressed in order to achieve success. For example, agency sanction in support of this approach is important in reference to case assignment. The practitioner will be working with many people, which may mean accepting fewer cases. Agencies need to consider reallocation of manpower. This can mean that the dollar cost of mental health will need reassessment.

Social network intervention is not a panacea for social problems and mental disorders. There are advantages and disadvantages. However, social network intervention is congruent with the profession's commitment to the biopsychosocial gestalt of human functioning.

# THE CONCILIATION COURT: A SOURCE OF HOPE FOR FAMILIES

*by*

*Hugh McIsaac*

## ABSTRACT

The Conciliation Court of Los Angeles County has pioneered in reconciling couples with marital problems and also helps families mediate custody and visitation disputes and makes recommendations regarding underage couples who apply for marriage. The goal of the professional counseling staff, in additon to helping families divert from the divorce process, is to assist unreconciled families to deal constructively with usual issues of separation. This paper describes the procedures followed, the extent of Court services, the guiding philosophy of serving the best interests of the child, and the dynamic issues that result in custody and visitation problems. Court experience has demonstrated an effective interprofessional effort of social work and law to help families who have marital problems.

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## INTRODUCTION

Established in 1939, the Conciliation Court of Los Angeles County was one of the first of its kind in the United States. The concept of conciliation, which has its roots in the ancient ecclesiastical courts and has been recognized for many years by local civil authorities, is codified by the authority under which the Conciliation Court functions. In reconciling couples with marital problems and settling differences amicably, the Court benefits the community as well as the individuals directly involved. Since 1954, 24,609 families have been reconciled by the Court. The Court also helps families mediate custody and visitation disputes. Eighty-three per cent of funding for this service comes from divorce filing and marriage license fees, while the balance comes from general county funds. The county also contributes indirect overhead costs. In 1980, there were 22 counselors, seven fewer than before the retrenchment of 1976.

The basic objectives of the Conciliation Court include:

1. Provision of a non-adversarial means of settling conflict within the Superior Court, with maximum participation of the parties involved as they take responsibility for their own individual and collective lives.
2. Helping families reconcile and divert from the divorce process.
3. Helping families going through the divorce process handle the crisis of dissolution effectively and settle their differences amicably.
4. Making recommendations regarding underage couples applying for marriage.
5. Reviewing policies and programs to make recommendations for the strengthening of family life, both inside and outside the court system.

## COUNSELING AFTER FILING OF AN ACTION FOR DISSOLUTION

The filing of a Petition for Conciliation does not stay an action for dissolution of marriage if the latter was filed prior to the filing. If, however, the Petition for Conciliation is filed prior to the filing of a Dissolution of Marriage action, no dissolution proceeding may thereafter be instituted by either spouse for a period for 30 days after the Court hearing.[1] In either case, the need for immediate action is apparent. As most counselors are aware, the filing of a dissolution action does not always represent a true desire to terminate the marriage; it is often a desperate cry for help. If the cry is not answered, the tragedy of an unnecessary dissolution may occur. The fact that 20 per cent of all divorce filings never become final indicates that marriage counseling in a court setting is an effective means for answering this plea.

## BENEFITS OF COUNSELING WHEN RECONCILIATION DOES NOT OCCUR

A Conciliation Court is more than a reconciliation service. Even in those cases where reconciliation is not possible, the parties derive positive benefit from the court experience. Professionals, through their here-and-now, reality-oriented counseling, assist the parties to terminate their marriage in a more benign and mutually satisfactory manner than would otherwise be possible. The purpose of the Court is "to protect the rights of children and to promote the public welfare by preserving family life and the institution of matrimony, and to provide means for the reconciliation of spouses and the amicable settlement of domestic and family controversies."[2] The intent of the law clearly embraces more than a reconciliation function. The Conciliation Court does not have the unrealistic goal of saving all marriages, but it *is* concerned with the *unnecessary* divorce. A Conciliation Court serves families. The fact that a family does not reconcile in the course of service does not mean that the counselor's concern for, and responsibility to, the family ends. In such cases, 12 marriage and family counselors offer an important and worthwhile service in helping the family to terminate the marriage with dignity and minimal trauma, and without the need to strike back. It is this need which often results in post-dissolution litigation.

Counselors recognize that a dissolution decree cannot and does not end parental responsibility to the children because "parents are forever." A dissolution decree terminates the husband-wife relationship, but neither parent is divorced from the children. Nor do problems stop when the decree is final. The goal with unreconciled families is to assist the husband and wife to "close the book gently" by focusing on the usual issues of separation, including custody and visitation, and continuing their joint responsibilities to their children in a constructive way. This service makes it possible for families to use the crisis of divorce as an opportunity for personal growth and fulfillment, rather than a vehicle for self-defeating behavior. Attorneys commend the assistance in dissolution cases when reconciliation is not possible. They report that counseling reduces tensions and materially assists in working out amicable agreements.

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[1] CCP Section 1770.

[2] CCP Section 1730

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## CONCILIATION COURT JUDGE AND PROFESSIONAL STAFF

The Conciliation Court consists of the Supervising Judge and the counseling staff, which includes the Director of Family Counseling Services, a Principal Family Counselor for Counseling, and a Principal Family Counselor for Training, Research and Staff Development, five interns, and two trainees who volunteer their time in exchange for supervised experience. Function of the judge is vital. While the judges do not engage in marriage counseling, they exercise direct control of the operation of the court, thereby determining the policies. As judges, they sign all court orders, including the Marriage Agreement, which, when signed, becomes an order of the court. In addition, and in furtherance of a program of public education, the judges appear before civic and professional groups.

The professional staff has specialized training in marriage and family counseling. All have a Master's or higher degree in the behavioral sciences and at least five years of post-Master's experience. The Court in 1978 also initiated a training program for behavioral scientists interested in working in the field of family law. The Court combines the strengths of the legal and counseling professions to meet the complex needs of families in family law.

## COUNSELING PROCEDURES

The law directs attorneys to be aware and advice their clients that all services of the Conciliation Court are without charge[3] and that all files, reports, or documents are confidential;[4] no outside party may inspect them, nor are they subject to subpoena or discovery process. The Court has three Spanish-speaking marriage counselors; no interpreters are needed for that language. However, if an interpreter is necessary for another language, an interpreter is ordered, and a fee charged. In addition, attorneys are directed to advise their clients that if the parties fail to appear at a conference, they will be charged for non-appearance.

Inquiries concerning the Court are often received either informally or by the filing of a Petition for Conciliation, without the filing of a petition under the Family Law Act (that is Dissolution, Separation, Nullity). In 1976-77, for example, 40 per cent of the families filing a Petition for Conciliation did not have a dissolution of marriage action pending. About half of these arose from an inquiry received by telephone or mail. When contact is initiated in this way, an initial conference date is set and the parties notified to appear. The other half of the cases arose when one or both parties came to the Court personally. They are seen immediately for a short conference to explain the services available. When the parties desire to proceed, they are assisted in filing a Petition for Conciliation. If both parties are present, a conference date is scheduled, and the conciliation process proceeds. If only one is present, a future conference date is scheduled and the other party is notified by mail of the date to appear.

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[3] CCP Section 1765

[4] CCP Section 1747

When a Petition for Dissolution of Marriage or for Legal Separation is filed, a "Confidential Counseling Statement" must concurrently be filed and a blank Confidential Counseling Statement served on the respondent. Court reviews the statement. In all cases where there are children under age 18 and the parties indicate an interest in counseling, they are sent two pamphlets: "A Personal Message to Parents" and "Parents Are Forever." If either or both have requested counseling, they are sent a letter encouraging them to file a Petition for Conciliation. If they do not respond by filing such a petition, no further follow-up is made. If, however, a Petition for Conciliation is filed, the full conciliation process is set in motion. When the Judicial Council introduced the form now in use ("Confidential Counseling Statement"), the Court developed a statement, "A Personal Message from the Conciliation Court," which attorneys attach to the Confidential Counseling Statement as a means of advising clients about the availability of the Court's services.

Conciliation conferences are conducted by marriage counselors with the express intent of helping the parties arrive at a reconciliation. However, if reconciliation is not possible, the parties are helped to reach an amicable settlement of problems related to permanent separation. The conferences are held in the counselor's office in the courthouse and are usually of one and one-half hours' duration. The number of conferences per case varies from one to six, with the average being three.

At the first conference the parties are seen separately for about one half hour each, to allow them to ventilate their feelings and thereby give the counselor an indication of their important concerns. During the last half hour of the conference, the parties are seen together. They are also seen together in subsequent conferences, with the method being that of encouraging them to verbalize their problems in order to arrive at solutions together. The same procedure is followed whether or not reconciliation seems possible. The Court has the power, infrequently exercised, to cite third parties for attendance at any of these conferences.[5] This may involve family members, including in-laws, or adult children, or unrelated persons.[6]

If after some counseling the parties agree to reconcile, they sign a contract to do those things necessary for a harmonious marriage. Once signed by the parties and the Supervising Judge, it becomes an order of the court and may be enforced by contempt proceedings. If, on the other hand, the parties conclude that they cannot or will not reconcile, the case is closed.[7] However, when a couple indicates a desire to continue their counseling on an ongoing basis, they may be referred to an outside agency or practitioner. Outside counselors are required to furnish the court with reports of cases so referred.

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[5] CCP Section 1766

[6] CCP Section 1763

[7] CCP Section 1769

Once the Conciliation Court proceedings have started, a blue sheet is inserted in the Family Law file indicating the pendency of the proceedings. While a Marriage Agreement is in effect, neither party can proceed with the dissolution of marriage action except upon termination of the Marriage Agreement. Additionally, and for the full period of its proceedings, the Court has the power to request the Family Law file, and if deemed necessary, may forward the file to the acting counselor.

When the conciliation process has been completed successfully and the parties have been reconciled, the Supervising Judge sends the couple a personal letter of commendation. Attorneys involved also receive a letter. At this point no further action is taken by the Conciliation Court.

## OTHER SERVICES TO THE COMMUNITY

*Branch Offices.* In addition to those already mentioned, the Court performs other services for the community. Beginning in 1967, Court established branch offices in several District Courts of the Superior Court. This program, introduced on an experimental basis to evaluate feasibility, has proved to be successful and represents another aspect of the Court's intent to make service easily accessible. There are now Conciliation Court branches in ten judicial districts.

*Premarital Counseling for Minors.* In 1970 the Conciliation Court began a program of premarital counseling with all minor couples applying for a marriage license when court consent was required in addition to parental consent. The counselor, following an interview with the parties involved, furnishes the judge responsible for making the determination, a recommendation as to their readiness for marriage. The Court can require premarital counseling for any couple applying for a marriage license in which one or both parties are under age 18. Raising the girl's age from under 16 to under 18 caused an increase in the number of minor couples requiring court consent. In implementing this law, the court operated under the assumption that premarital counseling is necessary for all such couples. For the first time in 30 years, California's escalating divorce rate has shown a decrease from 6.2 to 6.0 per thousand population. Some of this reduction may be due to the premarital counseling law.

It was the intent of the law that premarital counseling be provided by outside community agencies. The court has developed policies and procedures to implement this act and has enlisted the support of 60 agencies throughout the county. The court assisted these agencies to develop a counseling model which most of them now use and has undertaken research on the entire problem of teenage marriages.

*Postdissolution Counseling Regarding Custody and Visitation.* For approximately three years the Conciliation Court has been receiving postdissolution bench referrals for counseling as a means of reducing custody and visitation conflicts and, where possible, helping the parties reach amicable agreements. Three years of experience with this service have shown the value of such services to parents who have not achieved emotional separation despite the fact that they are legally divorced. The goals of this service are:

1. To help the natural parents reach an amicable agreement to insure that "the best interests of the child" are served.

2. To open channels of communication which have been clogged with unresolved anger and the need to strike back. These are usually problems that existed during the marriage and were exacerbated by the divorce.

3. To ascertain at what levels the natural parents are still emotionally connected in a self-defeating, destructive way. Parties are often connected by bonds of anger that have never been broken. These bonds impede communication, and this in turn makes it exceedingly difficult for the parents to resolve problems that must be dealt with in the best interests of the children.

4. To help parents accept the reality that although a divorce ends a marriage, it never ends the family where there are children nor the role of parent.

5. To involve stepparents in the total family system in a constructive way.

6. To help parents become more aware of the destructive impact of their conflicts on the children.

Procedurally, the goal is to counsel with the natural parents and, where indicated, with the children, stepparents, and other significant persons. As in other counseling services, the crisis counseling model is used. Findings are that short-contact counseling can be effective with these couples.

The counselor works out a written amicable agreement with the parties signed by the couple. Six weeks later the signature of the referring judge makes the agreement an order of court. This six-week interval allows the parties to return to the Court for a mandatory evaluation interview. If they then feel they can continue to implement the conditions of the agreement, the judge is asked to sign the court order. The Conciliation Court terminates its proceedings at the time of the six-week evaluation interview when the court order is signed. The parties are urged to return to their counselor if old problems erupt or new problems occur.

If at any time after the Family Law Department order has been made covering the agreement, the parties find that one or both are violating the agreement and they are counseled again in Conciliation Court without positive results, it is their responsibility to bring the matter to the attention of their attorneys so it can be placed on the Family Law Department calendar. In this way functions of the Conciliation Court and the Family Law Department continue to be clearcut.

A new procedure which intensified the mediation model by compressing mediation interviews into one day and referring agreements back to court after review by counsel has not only helped mediate disputes prior to trial, but has also made possible the creation of an enforceable order involving the attorneys as allies with the family and the court.

Court sees the parties on a short-contact basis (one to six sessions) during which significant others, including children and stepparents, are involved. When indicated and accepted by the parties, referrals to other community counseling services are made for ongoing counseling. Postdissolution referrals made by the bench regarding custody and visitation are all handled as privileged communications.

Counselors are finding that custody and visitation problems are often means that divorced people use to continue their involvement with each other. These divorced husbands and wives are still closely connected emotionally, for anger can be as binding as love. These cases involve a variety of problems including:

1. Difficulty in accepting the reality that the marriage is over.
2. Difficulty in accepting the role of being single.
3. An ongoing need to punish the other person, particularly in cases where the decision to divorce was not mutually acceptable. This is punishment for "leaving me and rejecting me." This need to punish may flare up when one of the divorced partners remarries and the other becomes a "hostility junky."
4. An ongoing need to communicate indirectly through issues of custody and visitation which involve the children.
5. Battles about children which may signify lingering hurt over lost love and represent attempts to hold on to the past.
6. Destructive and self-defeating tactics by one or both parents of divorce which may be a cry for help in their attempts to go from the married to the single state, from the old life to a new life.
7. Outward manifestations of conflict may mask the anxieties and fears in ruptured relationships, including divorce.
8. Rage and hurt at ending the role of spouse because identity and validation as a person have been played out in these engrossing roles.

In recognition of these complex issues, judges and commissioners, on a selective basis, refer couples for custody and visitation counseling during the divorce period.

Postdissolution court battles over custody and visitation demonstrate that in divorce there are many times when the legal issues, however important, are secondary to the issues of human psychological and social problems. Answers to these problems are usually found not in the courtroom itself, but in a counselor's office. A court can grant a legal divorce, but a divorce is not total without emotional separation. An order of the court does not have effect until it is heard, understood, and accepted by all parties.

This counseling service is another manifestation of concern for what is in the best interest of the child. To serve the child, the court must also meet the needs of divorcing and divorced parents and help them to deal with deep conflicts, rather than merely "processing" them.

In 1978, nearly half of the couples served were able to work out a written amicable agreement, with resulting benefits to themselves and their children. Whereas traditionally a court orders people to do and not to do certain things, this Court has allowed an unprecedented degree of self-determination in that the parties themselves with approval of the referring judge are modifying previous orders. Where no such orders have been made, the couples in effect work out their own order. This is consistent with a basic principle in counseling that when crucial decisions are made for people and not with them, the likelihood of compliance is diminished. The goal of all Family Law Department orders is to create conditions of order and harmony among people in conflict. When the court permits the kind of self-determination manifested in these cases, it in no way compromises its own principles. The end result is creating a set of conditions that the parties themselves feel they can live with and are more likely to follow.

## CONCLUSION

As late as 1960, court provision of professional marriage counseling service was unknown. Anyone suggesting such a service might have been labeled an impractical dreamer. Experience has demonstrated that the Conciliation Court concept is an effective interprofessional effort of the law and behavioral sciences to help families who have marital problems. Conciliation Courts are today functioning effectively in diverse jurisdictions in many parts of the world. It continues to be the purpose of the Conciliation Court to help families find hope, and where hope exists, to nurture it to a successful conclusion. In this manner, enlightened decisions about marriages can be made with self-awareness and understanding.

# WIDOW / WIDOWER OUTREACH PROGRAM (WWOP): THE SOCIAL WORK ROLE WITH MEMBERS OF A MUTUAL - HELP PROGRAM AND THEIR FAMILIES

*by*

*Helen C. Lucks*

## ABSTRACT

The Widow-Widower Outreach Program, a mutual help program within the San Francisco Jewish Family and Children's Service, functions under the supervision of a social worker to bring a variety of supportive services to the newly widowed elderly in the Jewish community.

The program utilizes widowed volunteers who reach out to the newly widowed, offering them emotional support and connecting them to the program of discussion meetings and social networking through which they may expand their friendships, while confronting the variety of adjustments of widowhood.

A self help group as a flexible resource to develop new reciprocal relationships replacing those which were lost is particularly relevant in old age when social isolation can be devastating in its effects upon the elderly and their families.

Its alliance with a social worker permits this program to offer consistency and structure to a population in a transitional crisis, as well as effective and timely intervention to relieve individual and family stresses resulting from widowhood in the later years.

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## WIDOWHOOD: A SOCIAL PROGRAM

The elderly widowed occupy a devalued status which creates a social problem simultaneously with personal bereavement. They lack positive role models; in fact, society has no clear norms regarding "old" behavior. Matthews[1] has described the demeaning status of being old in our society and how this contributes to a negative self identity. Former family and professional roles are forfeited for the negatively valued role of retired elderly widow or widower. One way an older person attempts to preserve a valuable self image is to have reciprocal relationships in which he feels useful, rather than "dependent and old." He may become manipulative in relationships with friends and family to protect a failing self-image. While adult offspring may be receiving rewards from multiple sources including spouse, children, work, and friends, the elderly parent may depend solely on a son or daughter as the source of rewards. He therefore capitulates to the offspring's definition of what their relationship should be in order to retain this source of libidinal supply.

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[1] Sarah H. Matthews, *The Social World of Women* (Beverly Hills: Sage Publications, 1979)

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Widowhood at any age has also been equated with dependency and devaluation. Friends turn away out of a fear of death and uncertainty about how to relate to the bereaved.

A lifetime of divided roles also creates problems for the widowed, left to live their remaining years on their own without adequate preparation. Practical skills of daily life and new attitudes appropriate for the new social status must be learned.

Lack of community resources to meet the needs of the widowed was brought to the attention of the Jewish Family and Children's Service of San Francisco in 1972 by a widowed retired nurse. She wanted to share with other newly widowed people the lessons she had learned from her own struggles. From this beginning, the Widow-Widower Outreach Program (WWOP) served nearly 100 people in 1979.

## DESCRIPTION OF WWOP

Housed within a family service agency and coordinated by a social worker, WWOP offers a flexible structure for preventive intervention by assisting the widowed elderly to develop functional behavior patterns and enhance their family relationships. By means of a social network, it offers multiple sources for reciprocal relationships and various models for living as an older widowed person. Modeled on Silverman's work,[2] WWOP utilizes Widow Aides, widows and widowers who reach out to the newly widowed on a one-to-one basis, offering the empathy and support of a peer. A social network is developed through an integrated program of discussion meetings, newsletters, social networking, spontaneous and planned social functions, and educational and informational meetings.

### *Philosophical Tenets*

The concept of self-help is a new-old approach to solving complex problems of survival for individuals who find themselves in a limbo where their social problems are unrecognized. By organizing their own collectivity, individuals with like concerns are strengthened by the mutual sharing of their problem.[3]

Grief is recognized as a normal response to death involving sequential stages of shock, recoil, and recovery. A program for widows must address the needs of members in varying stages of the grief process. While offering outreach and support to the newly widowed, it also serves as a social network and educational program for learning new survival skills.

The idea that early widowhood is a transitional phase is reflected in a program of group meetings which are open-ended in membership, attendance, and termination. Serving as a bridge back into the community, the program encourages members to move at their own pace and to find their connections to the community through their contacts in the program. While the median time of passage is two years, many remain for four or five years during which time they take an active role and experience gratification and expanding friendships.

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[2] Phyllis Silverman, *Helping Each Other In Widowhood* (New York: Health Sciences Publishing Co., 1974)

[3] Harold W. Demone, "Health and Welfare, Mutual Help Groups," *Directory of Mutual Help Organization in Massachusetts* (1974): 3-4

### *Membership*

Most members are middle-class Jewish widows in their late fifties through late seventies. Educational level ranges from high school through professional training. They tend to live alone, but retain some connection with families and community. Childless widows find themselves adrift when the spouse relationship terminates. Many newcomers to the city are overly dependent on an adult child and lack other connections. Retired widowers appear to feel even more helpless than the widows. Many lack skills in personal care, housework, and hospitality. They may also be inexperienced in verbalizing their feelings outside of the marriage relationship, and seem to require active reachout by the widows to make them comfortable. Both widow and widower feel devalued and sexless, beset with loneliness and self doubt, but find a sense of balance restored to their lives in the presence of the opposite sex which the meetings and other functions provide.

## KEY ELEMENTS IN THE PROGRAM

The intent of WWOP is to reach out to the newly widowed in the San Francisco Jewish community with widowed volunteers who, serving as Widow Aides under the supervision of a social worker as Coordinator, identify with the new widow and offer support for the safe unburdening of feelings, the consideration of alternative ways of coping, and become role models.

A local mortuary supplies the names of the newly widowed, and the list is distributed to the Aides at their monthly meeting for individual outreach. Aides select their own assignments. They then write a personal note, on letterhead stationery, to the bereaved, offering support and suggesting contact by phone and social meeting. When appropriate, the Aide invites the new widow to a discussion meeting with others widowed within the past month or two. With the alliance of the Aides, the Coordinator facilitates discussions which permit expression of feelings about loss and the sharing of reactions, experiences, and coping techniques. Informal contacts between meetings are encouraged as a means of bonding the members. Book lists, resource directories, and information on widowhood are distributed. New members receive the newsletter in which they are individually welcomed, and all members are encouraged to reach out to them.

Monthly discussion meetings on pre-selected topics are held for the general membership. Themes pertaining to the emotional and concrete adjustments of widowhood are considered. Programs use presentations by the members as well as by outside experts. In addition, meetings serve as a springboard for social networking, and for learning about community resources which could meet social, recreational, or educational needs. Attendance varies from twenty to thirty, with ten to fifteen at meetings for the newly widowed.

The monthly Widow Aide meetings, attended by eight to ten, are used for distribution of assignments, sharing each others' outreach styles both for support and improvement of techniques, and as a source of information about the effectiveness of the program and membership reactions. Aides, as the key persons in the program, must feel commitment to their work and be active in offering emotional support to the newly widowed, and socially connecting them to the program. In this way, the program serves its function as an outreach and as a connecting bridge back to the community.

In addition, the Aide role supports the Aides in the transition from recoil into the recovery phase of widowhood, which is successfully climaxed by termination or "graduation" from this role. This concept of the transitional role of the Aide has relevence to the reciprocal nature of the self-help program, and must be addressed in the organization process.

As the only continuous link in this transitional process, the Coordinator is simultaneously engaged in the process of recruitment of Aides and an effective working alliance which fosters the support and termination of current Aides.

The bimonthly newsletter serves as a means of communication about program activities. Since its inception, the newsletter has developed many unanticipated functions which give it a major role in the program. These functions include: a means of welcoming newcomers and encouraging further connections to the members; a source of recognition to members for their "outreach" and "inreach" efforts; a platform for the enunciation of program values, goals, learnings from discussions, questions to be explored, and new program plans; a public relations instrument to inform community agencies and prospective members about the program, and an effective tool for giving continuity to a transitional, open-ended program.

## THE SOCIAL WORK FUNCTION IN A MUTUAL HELP PROGRAM

A mutual help program rests on two central characteristics. Members in the group must share a life situation or problem which enables them to identify with each other's predicament. This identification is different from the empathy of a professional. Therapy occurs in the reciprocal relationship between the helper and the receiver. The receiver sees hope of mastery through the example of the giver. The giver gains validation of mastery and a feeling of usefulness. For the continuation of such a program, the rewards from the reciprocal relationship must be consistent with the purpose of the organization.[4]

The developmental history of WWOP seems to bear out these concepts. During its third year, the population changed to include a preponderence of people in the latter stage of widowhood who were impatient with outreach and desired instead to fill their lonely homes with social activities. This shift conflicted with the therapeutic goals of the program, causing the newly assigned Coordinator to consider some major decisions which might restore the program's relevance to therapeutic goals.

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[4] Robert S. Weiss, "Self Help Groups as a Therapeutic Method." Lecture at Harvard University, Cambridge, Mass., 1975.

It was noted that those participants who were widowed longer than five years had recovered from the transitional process of widowhood, and were seeking an organization for social activities. A time limit of five years was placed on eligibility for the program, which led to a large reduction in membership and meeting attendance, but left a core of people who needed the program.

Active recruitment of Widow Aides to replace those who had left permitted filling the vacancies with Aides who fit the therapeutic objectives of reciprocity and identification with the problems of grief and widowhood. Recruitment outside failed to bring volunteers whose objectives were consistent with the program. Their motivation seemed to emanate from needs (status, power, keeping busy) which were antagonistic to reciprocal relationships. Recruitment from within the program was accompanied by education of members about the grief process and their unique value to themselves and to each other in resolving their grief through active participation in mutual help. The social and psychological benefits which accrued to the Widow Aide who had experienced successful reciprocal relationships were described. This brought a resurgence of volunteers who could then be screened for their ability to make appropriate contributions.

In individual interviews the volunteers were encouraged to discuss their own widowhood and their expectations as Widow Aides. The Coordinator helped them identify those needs which they could fulfill as active Aides. This process brought in Aides with commitment to the program and its therapeutic goals. Their commitment was demonstrated by regular attendance, active contact with their new assignments, focused discussions during the meetings, and a general atmosphere of warmth and satisfaction. New members remained and became integrated in the program.

Once a new member attends the discussion meeting, the Coordinator's objective is to help him to find multiple sources of reciprocal friendships among the members. Open attendance and structured discussions of preselected topics had limited the attainment of these objectives. With the establishment of an in-reach committee, each member was encouraged to assume an active role which would be helpful to another member. According to personal preferences, members chose to take responsibility for hospitality at meetings, transportation, community events, home gatherings, outings, and other tasks. Social networks emerged which have sustained many members through recurring crises.

By means of a yearly luncheon for the Widow Aides and a New Year's reunion for past and present members, the parent agency gives recognition to the members for their unique contribution to the welfare of each other and to the community.

The program utilizes the alliance of social work and lay skills in the discussion meetings. The Coordinator stresses the unique contribution of the widowed themselves as the experts, utilizes social work skills in facilitating the discussion, and encourages socialization among the members. This model of interaction permits an open interchange between the members and the Coordinator as to which discussions work, and which may have become too painful for members to endure. In this way, the Coordinator is able to adapt professional techniques for a self-help support group.

Since the Aide role is therapeutic for the Aide as well as for the receiver of help, the Coordinator's relationship to the Aide is therapeutic as well. The social worker's role is to promote experience of success as an Aide by providing an accepting milieu in which outreach techniques and difficulties, as well as their own current widowhood problems and goals, can be openly shared and considered. In addition to developing skills in outreach, Aides often require support to terminate from their role. Having only recently found significance in the Aide role, a widow must come to terms with another loss in this step out of widowhood. By mutual recognition of the meaning of this step, and the assurance of continuing support by the Coordinator and the program, Aides can successfully terminate this role while maintaining social connections to the program.

Occasionally, an Aide may be unsuccessful in developing outreach skills. This failure can mean a loss of some newly widowed. The Coordinator needs to consider the importance of the Aide role for the individual, and to help him to utilize other natural abilities in social relationships. In this program, the individuals offered qualities of loyalty, genuineness, and concrete service to other members which brought reciprocal benefits to them and the program.

## FIVE WIDOWS AND THEIR FAMILIES

The easy accessibility of social work intervention in this mutual help program has proved to be an effective and timely method of easing personal or family stresses during successive periods of widowhood. A useful intervention has been the accessibility of individual counselling to ease particular stresses experienced by the members when needed.

> Selma Zak preferred to utilize the social network and discussion meetings during her first year of grief. She then requested individual counselling to discuss rejection by her children. Private sessions in which she experienced acceptance of her feelings, as well as recognition of her coping capacity, permitted her to use her energies for maintaining her friendships in the group. In the third year, she and her daughter requested joint counselling to resolve conflicts in their relationship. This intervention enabled the pair to come to terms with their new relationship as single, adult women and relaxed the quality of duty and obligation which was threatening to destroy their contact.
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> Clara Irwin used the discussion meetings to unburden her grief over the death of her husband so that she could maintain her equilibrium with her son who was suffering a fatal illness. In a later phase, she and her son requested a joint home visit to explore housing alternatives for Mrs. Irwin, who had recently been hospitalized. The unspoken request concerned fears of losing each other and a need for reassurance by the social worker that they would not be abandoned. Later, when the son was dying in the hospital, members who were concerned about

her requested intervention by the social worker. By connecting her to a supportive hospice, the social worker reduced the helplessness experienced by friends, and enabled her and her son to experience community support in their loss.

The combination of individual counselling and the support of this mutual help program has also been effective in reducing family stresses. The following cases illustrate this approach.

Esther Blass was feeling suffocated by her newly widowed mother, Mrs. Moss, who leaned heavily upon her for every detail of her daily life. A newcomer to the city, who suffered impaired mobility, Mrs. Moss became phobic about being alone at home, on the streets, or shopping. Her fears and dependency threatened the stability of her daughter's marriage. The Blasses began to withdraw from Mrs. Moss, which only accentuated her fears of abandonment and caused her to become even more demanding of her daughter. The Widow Aide assigned soon found herself swamped by their expectation of her total attention and brought her problems to the Aide meeting for discussion. She was supported in setting realistic limits to the time and attention she could give Mrs. Moss. By her example, Mrs. Blass was encouraged to set similar limits. Through individual counselling, the Coordinator helped Mrs. Moss to recognize how her dependency was disturbing her daughter's marital relationship and preventing her from making friends in the program. In a stoic manner, she began to make small changes in her behavior, gradually improving in confidence and independence. After a year and a half, she still felt isolated; the Coordinator therefore encouraged her to become an Aide to help her reach out and possibly regain the intimacy she missed. She grew in her sense of independence, and came to regard her fears as challenges to be overcome. She became a loyal friend to others, particularly the ill and the homebound. She achieved the status of being warmly regarded and included in most social gatherings of the group. Her family expressed pride in her accomplishments and credited the program for its service to the family as a whole.

Betty Lee, quiet and tearful when newly widowed, suffered frequent hospitalizations and appeared to her friends in the program to be abandoned by her children. She requested counselling by the Coordinator, who found that she lacked insight into her own contribution to her difficulties and was blaming her children for their selfishness and greed. As efforts to involve her children were rejected, she turned to friends in the program for affection and sympathy. In her third year, she and her daughter sought counselling which uncovered a long standing symbiosis from which the daughter had only recently emerged. Her mother's widowhood aroused her panic that she might again be absorbed into her mother's life, and she turned away. Mrs. Lee was helped to regard her daughter as she would a friend whose independence and privacy deserved respect. Mutually reassured, they experienced an easing of tension, and the counselling was terminated.

Mrs. Cohen, new to the city, had subordinated her life to an alcoholic husband, gaining secondary pleasure from being needed and being a "good Jewish wife and mother." As a widow, she felt both guilt and fear for enjoying her unexpected freedom, and needed reassurance by a "traditional widow" to ease her guilt. Her need for personal freedom also conflicted with her image of how to be old. She felt that her daughter was telling her to "be a grandma," because their conversations seemed to focus on her grandchild. She was bored and preferred more stimulating discussions about her new growth and ventures. In individual counselling, she expressed these concerns and gained new perspectives. Bolstered, she used the discussion meetings to air her "different" viewpoint on living alone in her later years. She continued to telephone other members for reassurance. As she explained it:

> My message to my daughter all her life was that I'll need her to take care of me when I'm old, and so she is trying to do this. But I'm learning that getting old doesn't mean I can't take care of myself. Now I've taught her that being a good daughter and mother means to give each other space and trust to run our own lives.

These examples describe the interplay of group and individual counselling available in a self-help program within a family agency. It demands that the Coordinator be flexible in the multiple roles of facilitator, coordinator, counsellor, and peer. As in other helping relationships, the Coordinator is a role model for the group and as such is under constant scrutiny. Just as in therapy, good rapport can overcome mistakes. In fact, it is essential to the relationship that a human bond be established in which equality is preserved within an atmosphere of mutual respect. Just as the good teacher learns from the student, the Coordinator learns from the members.

## *Summary*

In the San Francisco community the Widow-Widower Outreach Program is unique in its combination of widow outreach, discussion programs on widowhood, social networks, and the services of a social worker coordinator who can intervene in individual and family problems for the reduction of stress. The program receives growing recognition by the community for its effectiveness with the bereaved elderly, evidenced by increasing referrals and requests for consultation. Homogeneity of common problems, age, middle class values, living independently, and a degree of social-isolation seem to be the major factors contributing to bonding. As the group has absorbed non-Jewish members, the sectarian factor seems less important.

This program, combining professional and self-help modalities, is a functional and effective strategy for intervening in family relationships at a time when the multiple losses of later years can become major stresses to individuals and the families on whom they depend.